MEDICARE GAPS AND LIMITATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

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CONTENTS

MEDICARE GAPS AND LIMITATIONS

TUESDAY, OCTOBER 18, 1977

U.S. House of Representatives,
Select Committee on Aging,
Subcommittee on Health and
Long-Term Care,
Washington, D.C.

The Subcommittee on Health and Long-Term Care met, pursuant to notice, at 10:05 a.m., in room 2202 Rayburn House Office Building, Hon. William S. Cohen (acting chairman) presiding.

Members present: Representatives Cohen of Maine and Drinan of Massachusetts.

Staff present: Louise Bracknell, majority staff director, and Cynthia Hilton, minority staff director.

OPENING STATEMENT OF CHAIRMAN WILLIAM S. COHEN

Mr. Cohen. Ladies and gentlemen, I am going to convene this hearing this morning. It is a unique opportunity for me. I must say though, it comes at the expense of some of my colleagues. Unfortunately, Chairman Pepper could not be here this morning because his wife is ill and several other Members either have conflicts or other difficulties in arriving here, so I have the unique opportunity to chair this hearing, at least temporarily, until a Member of the majority party comes through the door, at which time I will yield the gavel.

I would like to make a brief opening statement, if I might, and then we will have the first witness.

I welcome this opportunity to participate in the first of what I hope will be a series of hearings on the gaps and limitations in medicare coverage. As I see it, there are two essential shortcomings in coverage: one of total dollar coverage and the other of uncovered services.

The medicare program held tremendous promise for meeting the acute health care needs of the elderly when it was first enacted in 1965. Unfortunately, we have not seen the fulfillment of that promise. Medical technology and the effects of inflation on the fixed incomes of the elderly have reduced cost coverage to under 40 percent of the total dollar spent on health care for the elderly. On the average, the elderly are now paying more out-of-pocket for health care than they did when the Medicare Act was first adopted. Costs again are slowly closing the door to medical attention the elderly so desperately need.

As evidence of this, Secretary Califano recently announced a 16-percent statutory increase in medicare deductibles and premiums scheduled to take effect on January 1, 1978. When the medicare program was enacted, these out-of-pocket costs along with copayments were to deter

the unnecessary use of services. However, such large payment liabilities have had the effect of also deterring the use of appropriate primary care services. I would hope that this issue might be addressed this morning.

For my own part, I intend to consider the feasibility of restructuring medicare by combining parts A, which is hospital insurance and B, medical insurance of medicare to form a single entitlement with one deductible, eliminating program premiums and coinsurance requirements. I think more discusion is needed on the impact of catastrophic health care costs on the elderly.

As for the uncovered services, the subcommittee has initially selected several major services which clearly point out our legislative shortsightedness in meeting the vast majority of health care needs of the elderly. Medicare is oriented to the coverage of acute episodic illness, and yet the illnesses of the elderly tend to be chronic. Health maintenance, and not cure is more often within the possibility of health care treatment for the elderly. Certainly outpatient drugs, preventive medical services, and more flexibility in the delivery of home health care would serve to delay the need for other more costly types of care.

According to a report by the National Center for Health Statistics Research, drug usage by the elderly accounts for roughly 25 percent of all out-of-hospital drug expenditures although the elderly represent only 10 percent of the population. Furthermore, few have effective drug coverage under personal health insurance or any employee health plan. So the report concludes that, "For some elderly patients, a physician may order hospitalization simply to make expensive drugs available as a medicare benefit."

I have long been an advocate of the benefits of preventive medicine and health education, and the absence of such coverage is of concern to me. Certainly, when we are willing to deal with the need to control soaring health care costs, the adage of "an ounce of prevention is worth a pound of cure," takes on more meaning. Legislation that I introduced on health education was used as a model for the enactment of the Health Promotion and Disease Control Act of 1976. This year our subcommittee also held hearings on hypertension and the testimony at the time of those hearings underlined the cost-effectiveness of testing for high blood pressure as a harbinger of more serious complications. This is just one of the reasons why I introduced legislation to provide coverage under medicare of physical examinations for the elderly.

Likewise, I should indicate that I am also considering the possibility of drafting legislation which would require health and life insurance companies to offer reduced rate premiums for individuals who practice certain health promoting behaviors.

Our subcommittee and the full House Select Committee on Aging has been extremely interested in expanding the health care options available to the elderly, thereby reducing the demand for costly inpatient care. Secretary Califano has stated that as many as 100,000 of the 700,000 people in the Nation's acute care hospitals do not need to be there and could be better cared for at home. This extra cost amounted to approximately $2.6 billion last year.

In looking specifically at the 1 million institutionalized elderly themselves, HEW estimates that between 14 and 25 percent are there because there are no alternative methods of care. These are just two

examples of where funds could be better used to pay for the costs of home care. However, the requirements and the current law restrict the availability of inhome treatment, which appeals so much to the dignity and independence of the elderly themsleves.

Finally, I would note the inadequacy of the coverage of mental health services. My own concern in this field led to some field hearings that we had last year in Maine. Clearly, if persons over the age of 65 still constitute 25 percent of the suicides in this country we are not meeting needs.

I look forward to the comments of our witnesses today and it is my firm belief that if we as a Nation are not prepared to guarantee essential health needs of the elderly, we cannot hope to enact a viable program of national health insurance for the remainder of the population.

Before we hear our first witness, I would like to submit for the record the statement of Chairman Pepper, as I stated earlier, he is unable to be here with us this morning.

PREPARED STATEMENT OF CHAIRMAN CLAUDE PEPPER

Since its enactment in 1965, medicare has been a God-send to millions of elderly and disabled Americans, providing a hedge against acute, catastrophic illness which finds so many of these citizens hospitalized each year.

But much is wrong with the program. We know that the elderly pay more now for health care than they did before Medicare was enacted 12 years ago.

And the current program either denies coverage, or give precious little attention, to many of the most serious health problems of the aged.

It denies coverage for eyeglasses, hearing aids and dentures which are among the most critical needs of the elderly.

It makes home health care almost impossible to receive, because of the restrictive requirements that home health follow at least a three-day stay in the hospital, that it be reserved for the homebound, that the services be by "skilled" only, and that the visits be limited to 100.

The current acute, episodic illness orientation of Medicare denies preventive health services, which could save lives and dollars, and covers only the catastrophic illnesses which occur because we have not done anything to prevent them.

Medicare provides no outpatient coverage for prescription drugs, while the elderly, who make up less than 11 percent of the population, account for about 25 percent of the prescription drugs. The bill for drugs and drug sundries for the elderly in fiscal year 1976 was $2.78 billion. About 86 percent of this came out of the pocket of those who can least afford to pay, the elderly themselves.

Medicare provides only the most meager coverage for mental health services, despite the fact that 25 percent of the suicides in this country are committed by persons over 65. Medicare will cover only 50 percent of the cost of out-patient psychiatric services, or $250 annually, whichever is less. This figure has not been revised since Medicare was enacted in 1965, while the costs for all forms of medical care have skyrocketed in those dozen years.

Finally, we need to consider the growing burden that falls to each medicare beneficiary who finds that his or her medicare coverage shrinks as health care inflation worsens. This problem is most vividly exemplified by the rising inpatient hospital deductibles. Secretary Califano has announced that beginning on January 1, 1978, medicare patients will have to pay the first $144 for hospital stays. After 60 days, the copayment will rise to $36 daily, and after 90 days of hospitalization, the patients will have to pay $72 daily out of their own pockets.

This 16.1 percent increase follows closely on the heels of the January 1977 increase of 19 percent. That is more than a 35 percent increase since December of 1976. The elderly, most of whom live on fixed incomes, simply cannot afford monumental increases of this kind. I have introduced legislation, H.R. 9172, which would hold these increases off for 6 months, until we can develop a hospital cost-containment bill that is effective and until we can find another method of offsetting these costs.

Our job today is to highlight for the Congress and for the public the problems which keep the medicare program from being all it should and could be. Let's face it, we do not have health care in this country. We have sick care.

We must solve these problems as we move toward national health insurance, but we cannot wait for national health insurance. Twenty-three million elderly persons look to us for a solution now.

Mr. COHEN. I also wish to have inserted in the record on behalf of the chairman, a paper which has been prepared by the Library of Congress entitled "The Aged and Their Health Expenditures." Hearing no objection, it is so ordered.

[See appendix 1, p. 33 for the paper.]

Mr. COHEN. Mr. John Martin, former U.S. Commissioner on Aging is our first witness. Currently, he is a consultant to the National Retired Teachers Association/American Association of Retired Persons, and it is in that capacity that he is with us today. Mr. Martin, welcome to this hearing.

STATEMENT OF JOHN B. MARTIN, LEGISLATIVE CONSULANT, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY THOMAS ELWOOD AND FRED WEGNER

Mr. MARTIN. Thank you very much, Representative Cohen. I am glad to be here today on behalf of the 11-million-member NRTA and American Association of Retired Persons.

I have with me two of our experts, Thomas Elwood, who is our expert on long-term care and Fred Wegner, who is our expert on drugs and drug typings and I think maybe they will be able to add something to our deliberations today.

While medicare has been adequate in defraying a major portion of the costs associated with acute medical care, there are serious omissions which have a detrimental effect on older persons. The lack of coverage for long-term care and the absence of catastrophic protection have a devastating financial impact on those who have inadequate resources.

Also the program has failed to provide a complete benefit package, maintenance and preventive services, home health care and out-of-institution drugs.

In view of the constraints on time, I am going to restrict my statements to the issue out-of-institution drugs. We are very much concerned about the other issues, but we think those will be covered by other witnesses.

Ever since the Medicare Act was passed in 1965, we have contended that it ought to correct the most glaring deficiency in the Federal health program, namely, the lack of out-patient prescription drug coverage.

Indeed, the Senate passed drug benefit amendments to medicare in 1967, 1972 and 1973 only to see those proposals lost in conference.

Throughout the past decade, the concept of an out-patient prescription drug benefit under medicare has enjoyed the support of national, State and local associations of older persons and the HEW Task Force on prescription drugs, the 1971 White House Conference on Aging, the Presidential Task Force on the Aging, and the Social Security Advisory Council.

Other approaches have been suggested in this session of Congress by Senators Kennedy and Thurmond and by Senator Frank Church.

The circumstances which support the need for out-patient prescription drug coverage are these:

The elderly are expending some 25 cents out of each out-of-pocket dollar for drugs and drug sundries. Payments for drugs represent the second highest personal health care expenditure.

Because medicare does not cover out-patient drugs, over 80 percent of the amount spent by the elderly for drugs and drug sundries is paid out-of-pocket.

For those over 65 who comprise 11 percent of the Nation's population, they account for one-fourth of total annual prescription drug use.

Over 40 percent of the elderly suffer from some form of chronic illness that limits their activity. This is twice the incidence of chronic illness among those in their middle years and five times that of younger persons.

The aged spent $72 per person in 1974 for prescription drugs which was nearly two-and-a-half times the $30 average per capita expenditure for all age groups.

Since many elderly are fortunate enough to get by with no or few prescriptions this average per capita picture does not really show the true situation. Our associations did a more meaningful survey of drug users among our members and we found that expenditures between $200 and $1,000 a year were not uncommon among the respondents. Amazingly this represented from 10 percent up to as much as 45 percent of their incomes.

Another unfortunate fact is that average individual prescription drug expenditures by those in the two lowest categories of family income are substantially higher than for elderly individuals in higher family income brackets.

The amount of drug expenditures compared with income is particularly a problem with an elderly population where fully one-fourth of the individuals are below or near the poverty category.

Some proponents of a drug benefit for the elderly program argue the logic and value of beginning with a program limited to a small but needy segment of the population. It is a forerunner of the universal coverage under national health insurance. Arthur Hess, former Deputy Commissioner of the Social Security Administration, has made this point in a paper recently written by him. We approved this correction in the revision of drugs or the drug program because we think that if mistakes are made they can be smaller mistakes and we can have an opportunity to learn from a limited and manageable program.

While the American Association of Retired Persons has strongly advocated drug coverage for the elderly for over a decade, we are flexible about the provisions of such a program. We realize that it may cost as much as $3 billion and for that reason we favor stringent restraints on costs.

An effective and efficient mechanism for establishing a ceiling on reimbursement to pharmacists for the costs of the drug products and their professional services is essential. The HEW's maximum allowable cost program which has been slow to get underway is a reasonable step toward that objective, but there are necessary improvements which need to be made in the programs.

The primary problems with the maximum allowable cost program, in our opinion, is its failure to reach down to the drug manufacturing level with any kind of effective price policy. It makes no

sense whatsoever to us to attempt to limit reimbursement payments on drug products at the retail level while allowing manufacturers unbridled freedom to market their products at whatever price the traffic will bear and at the wide variations in price for the same product that has shown up in HEW's surveys.

We think that it is essential that a drug benefit program include a price policy with respect to manufacturers' wholesale drug prices. Although we are not wedded to a single mechanism, we think that the policy must guarantee stability in prices for a period of at least 6 months and must require review or negotiations between the Goverment as payor and the drug firms as providers in order to constrain inflationary price increases.

Our associations feel the need and the necessity of a drug benefit for the elderly, but we also insist that effective cost constraints be made an integral part of such a program.

Our 1977 legislative program contains several objectives which relate to cost containment. These include:

Federal generic substitution and prescription price posting laws.

A national formulary of prescription drugs; a national compendium of drugs; patent holders required to license their product when costs have been recovered and prescription drug advertising, promotion and sampling should also be subject to Federal limitation.

The universal use of established generic names of prescription drugs should be required in prescribing, dispensing, labeling, advertising, and promotion.

Another fundamental requirement of a good drug benefit program is public representation. By this we mean public representation on the planning, policy, and administrative levels.

The oversight of Federal programs by Congress is a useful and acceptable method of insuring public accountability, but we believe that the insight of public representatives participating on planning, policy, and program boards will provide a public accountability which is closer and stronger and more effective.

If there is wisdom in reaching universal and comprehensive drug coverage in incremental stages, our associations can support even a scaled-down program if the most disadvantaged elderly are initially in it. Those who should comprise this group at least include all citizens 65 years of age and older or chronically ill. While it might be more desirable to provide free drug coverage we recognize the likelihood that there may have to be some cost-sharing by patients. If the eventual passage of a bill rides upon such provision, we could support the inclusion of a minimal copayment feature.

Mr. Chairman, this concludes my statement and we are happy to be here to answer questions. Thank you.

[See appendix 2, p. 53 for Mr. Martin's prepared statement.]

Mr. COHEN. Thank you very much, Mr. Martin, for a really comprehensive statement.

I would like to ask you a series of questions that Chairman Pepper would put to you were he here, and in his absence I will ask them for the record, and then I will ask you a couple of my own.

First, exactly what coverage is currently provided under medicare for drugs?

Mr. MARTIN. Well, inhospital drugs are covered, but out-of-hospital

drugs are not covered. This is the major part of the expense for drug users.

Mr. COHEN. So under current law there are no outpatient drugs that are covered by medicare for reimbursement?

Mr. MARTIN. Right.

Mr. COHEN. In light of the support for the drug program which has existed in HEW, the Social Security Advisory Council and elsewhere, why do you think the Congress has failed to amend the medicare law to provide drug coverage?

Mr. MARTIN. Simply its cost, Mr. Chairman.

I think that everybody agrees who studied the problem that coverage ought to be part of the program for the elderly, the medical program, but it is an expensive program and that is one reason why we suggested at the start of it all it should be done on an incremental basis with a limited coverage.

Mr. COHEN. When an elderly person simply cannot afford the medicines such as insulin for diabetes, what happens, do they go without it?

Mr. MARTIN. Well, what happens is they go without food and they go without clothing. They go without whatever they have to go without in order to buy their medication.

If you are told by the doctor that you have got to have such and such medication, you do almost anything to get it.

Mr. COHEN. Do you know of any instances where medicare patients have died because they could not afford to pay for the lifesaving drugs?

Mr. MARTIN. I do not know if we can spotlight any such case where there has been an actual death, but we certainly have had lots of correspondence indicating the terrible hardship that it brings on older persons to have to purchase drugs out-of-pocket.

As I indicated in my testimony this may run from $200 to $1,000 a year. If you are talking about taking $1,000 a year out of the pockets of somebody who has $2,500 a year to live on, you have a pretty bad situation.

Mr. COHEN. Mr. Martin, you indicate that your associations could reluctantly support a drug program which included copayments by recipients if it were necessary for the enactment of a drug program. In hearings earlier this year on the medicaid program, this subcommittee focused on the hardship that copayments can bring to bear on the poor, especially the elderly poor and the question that Chairman Pepper would raise is would it be better to find another way that we could meet the cost of the drug program that you suggest?

Mr. MARTIN. If there were some better way, Mr. Chairman, we would be glad to see it. We are not enthusiastic about copayments, but we recognize that in view of the cost of the program it may be necessary to make some provision for a small, minimum copayment.

Mr. COHEN. Finally from Mr. Pepper: since the witness who was to discuss the growing burden of inpatient hospital deductibles is not going to be here, I wonder if you could tell us if you have any suggestion as to how we might solve the problem of out-of-pocket expenses for hospital and nursing home care. These, as you know are statutorily related to hospital costs, which are rising twice as fast as the other components of the cost-of-living index.

Mr. MARTIN. Are you referring to the increases in parts A and B, reimbursement?

Mr. COHEN. Yes.

Mr. MARTIN. Well, we have taken a position similar to a position that Congressman Pepper takes in his bill on this subject that would delay increases in costs that are scheduled long enough to get some kind of cost containment bill in effect.

Mr. Elwood, do you——

Mr. ELWOOD. I think that pretty much sums it up, John. Our great concern has been the containment of health care costs and particular emphasis on hospitalization. Even though we know that social security beneficiaries receive an increase each year based upon the cost-of-living that is nowhere correlated with the increase in the part A deductible for hospitalization which is now scheduled to go up 16 percent this year. Last year it went up 19 percent. So until we get some mechanism in place for holding down these costs, I think it would be advisable to try to install some type of a break for this group of beneficiaries.

Mr. COHEN. Mr. Martin, you referred to the value of generic drugs in your testimony. How does the AARP encourage the use of generic drugs and do you know of any instances where the health of any elderly individual was threatened by generic substitution?

Mr. MARTIN. I will answer the last question first. We do not know of any case where it has been threatened by generic substitutions.

As far as the first question is concerned. we have been very active in trying to obtain generic drug laws in the various States. We have taken the position that the average person could make substantial savings in obtaining drugs if the pharmacist were allowed to substitute the generic rather than the brand name drug. The brand name drug may itself sell for anywhere from 10 to 20 times more than the generic drug and there is no excuse for this; at least there is no excuse for it for the people who cannot afford to pay the prices of that sort.

Mr. Wegner, do you want to comment on that?

Mr. WEGNER. Yes; I think this is one of the most familiar places we can effect cost savings in the drug program for the elderly is the use of generic drugs which will entail a substitution by the pharmacists for the doctor who writes his prescription by brand name.

I think it is fair to say our associations have gone to battle for drug substitutions in this country and have indeed helped enact laws in 32 States.

Mr. COHEN. Well, the reason I ask the question about the substitution is because, as you know, the major drug manufacturers maintain they spend millions of dollars each year based upon thorough research and that to allow substitution without adequate research and development could be detrimental for the patients who use their drugs, and second. those substitutes are simply benefiting from the millions that they are investing in research. So that's the reason for the question as to whether there have been any catastrophic consequences as the result of using generic drugs.

Mr. WEGNER. We are well aware of what the major drug companies say.

I might say that the cost of the ingredients and the costs in labor in the manufacture of drugs is a very small part of the price. The

major components of the drug price for a brand name drug are the advertising and promotion that go into that drug. The profits that are made and the research and development that have gone into that drug. Of course, there is no generic drug until the brand name comes off patent after 17 years.

The HEW task force on generic drugs feels that the manufacturer or the innovator firm has recouped his R. & D. costs in about 3 years. So it seems sensible to us that the price of a brand name product should fall after 17 years, after the patent protection is expired. That does not seem to happen in this country and the reason is because the drug companies have brainwashed the physicians so long that they keep prescribing by the brand name and the patient is not able to take advantage of the savings that we have from generic drugs.

Mr. COHEN. This has nothing to do with this hearing, but I just heard on the radio coming in this morning where local or domestic beer manufacturers have discovered that since there is a tremendous volume of imported beer coming into this country with a very high price, they have decided to simply manufacture the imported beer, still call it imported beer at the same kind of price. Maybe that has some relevance, I'm not sure.

Mr. Martin, on page 8 you recommend the consolidation of all federally funded drug programs. Outside of medicare and medicaid what other drug programs are you aware of?

Mr. MARTIN. I will call on my expert for that.

Mr. WEGNER. Well, there are several now. CHAMPUS for Federal civilian employees and their dependents, the VA.

Medicare and medicaid are by far the largest users at the time. It just seems to us what we are really leading up to, I believe, is drug coverage under a national health insurance plan, whatever plan that may be. So why not—knowing that that is going to be the ultimate destination we all seek, why not lead up to that program and consolidate all the drug programs at this time.

Mr. COHEN. On page 8, Mr. Martin, you also recommended the establishment of a national drug testing and evaluation center to test all new drugs before they are placed on the market. As you know, the Food and Drug Administration was established to guarantee the safety of drugs and, since the passage of the Delaney amendment, to guarantee the effectiveness of the drugs also. You are also aware there is currently a great deal of debate as to whether or not the Delaney clause ought to be retained and I wonder about your opinion of the clause and, then given the cost associated with the complete drug coverage under medicare, should the effectiveness requirement be retained?

Mr. MARTIN. I would favor retaining the Delaney clause and so far as the last question is concerned it seems to me that——

Mr. COHEN. Well, to phrase it another way, in your opinion would the time delays in proving the effectiveness of drugs be outweighed by the need to get, at least, safe potentially beneficial drugs?

Mr. MARTIN. I think that we ought to be mighty sure before we put a drug out on the market that it is going to be safe and effective and I do not see any reason for worrying about an extra year or two in testing to make sure that that is an effective drug. I do not think that for urgency or for profit or any other reason we should hurry the intro-

duction of a drug in the general market. It can be used for testing by people who know what they are doing, but—we are agreeable to a testing program, but we do not want to see a flood of drug products put on the market that turn out in the next 10 or 15 years to be cancer causing or something of that nature.

Mr. COHEN. Thank you very much, Mr. Martin.

Our next witness is Dr. Sidney Shindell, who is president of the Association of Teachers of Preventive Medicine. He is professor and chairman of the department of preventive medicine at the Medical College of Wisconsin.

Dr. Shindell, welcome to the committee and we will be pleased to hear your testimony.

STATEMENT OF DR. SIDNEY SHINDELL, PRESIDENT, ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE, PROFESSOR AND CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE, MEDICAL COLLEGE OF WISCONSIN

Dr. SHINDELL. Thank you, Mr. Cohen.

Since I have already been identified, I don't see any need for me to reread page 1 of my testimony.

This hearing, as you yourself indicated, is devoted to the examination of gaps and limitations in the current medicare coverage and I would like to talk specifically to these issues. I would like to first make some observations.

The first is that you made my speech in your opening statement, but I may have a few points left that I would like to cover.

Mr. COHEN. That is a dexterity that we develop during the course of campaigning for election to try to state our position first.

Dr. SHINDELL. Well, you have done very, very well. It is just that you did not leave me very much to say.

The original purpose of medicare, as instituted a dozen years ago, grew out of a concern for segments of our society that had the greatest difficulty in obtaining hospital services for acute illness. As we all know, simply expanding purchasing power to obtain care for acute illness resulted in an expansion of the delivery system to provide such services and this has been accompanied by a steadily increasing expenditure from tax sources for medical and hospital care.

The increased expenditure is due in part to the steady rise in medical care costs generally, but also is the result of the fact that I think the principal needs of the elderly are not being addressed.

My problem with the way medicare operates is that it addresses a very restricted portion of the needs of the elderly and it places emphasis at the wrong time and the wrong place. It is true that in any one year, about a third of the population 65 and over experiences hospitalization of about 12 days. This means that on any one day only 1 percent of the aged population is in an acute short-term hospital. And while long-term institutional care is likewise significant in amount, the fact is that only about 5 percent of the elderly are institutionalized across the country.

Care for acute illness, of course, is essential as is institutional care for those whose physical condition has deteriorated irreparably. However, the major health problem faced by the elderly is neither the

acute disease nor irreparable deterioration. As medical technology has become more and more successful in managing acute episodes, increasingly our problems become those of slowly progressive chronic disabilities.

It has taken us some time to recognize or realize that if we ever hope to deal with progressive chronic disabilities we must address them before they reach the stage of hopelessness and incurability. We do not drive our automobiles to the point where they become disabled and then try to fix them; why do we then think that the human body can operate effectively without preventive maintenance?

Mr. COHEN. Could I interrupt you just for a moment here, Dr. Shindell.

It is kind of frustrating to me as a legislator. I drew a bill up this year called "The Periodic Physical Examination Act of 1977" thinking that it would be very beneficial to try and turn this country's attention to a preventive medicine by requiring—having a policy whereby we encourage individuals to take periodic check-ups, less frequently at younger ages, and perhaps as we get higher up on the spectrum, much more frequently.

That bill was met with a great deal of apathy on the part of the medical profession, particularly and it seemed to be that their response was there is no uniformity in the testing procedures that would identify—that would serve to identify specific illnesses. Again, as a layman this was very surprising to me and yet there seems to be no general support for the concept of trying to encourage periodic physical examinations within the medical profession itself. So I am a little bit bewildered by that.

Dr. SHINDELL. There was no general support for Columbus's trip to this country as many felt he was going to fall off the end of the world.

I suspect that was too flippant an answer. The whole concept of prevention, screening with followup, the assessment of risk factors rather than addressing frank disease at the moment is something that is coming into currency. I would say in the last 10, 15, 20 years this concept has developed slowly and it is not yet completely accepted. As I state later in my prepared testimony the problem is that screening alone is of little value. It is like bidding a hand and not playing it. It is only half the game. Screening is a beginning and unless you are prepared with a followup system, unless you are prepared to do something about what you find, then it really doesn't pay to do a test. I think that much of the apathy is that people have not become convinced that they should be addressing risk factors rather than evident disease or have not seen effective followup systems.

You cannot justify screening today on the basis that it is going to pick up a disease that we didn't know about before, but what it can do is give you an assessment of an individual in terms of the likelihood of this individual's future state of health. This we have not yet addressed very well, but our techniques are improving.

Professionals in the field of preventive medicine, including occupational medicine, represent only 1.9 percent of the profession and it is sad to say that this is so. We represent a distinct minority group, but some day our colleagues will believe us, and I think they are beginning to at the moment. So I am not at all surprised at the apathy that you

have experienced, but I think that the time for thinking in terms of prevention is going to come. Now, the suggestion that I have built into my testimony is, I think, a little more comprehensive approach to care makes more sense than addressing episodic illness and rather than stay with the prepared text let me just talk about it a bit.

I think the real problem of cost in medical service in general and in the medicare program in particular is that if you do not address the right problem at the right time you are doomed to address it again and again. We all ask our secretaries why is there never time to do a letter right in the first place, when there is always time to do it over.

I think much of medical care is doing over and over again what has not been done right in the first place.

What I would propose is that every individual, certainly every individual 65 and over, ought to have a physician with whom he or she identifies, a primary care physician who is paid on a capitation basis for a year's worth of service, whatever that service happens to be. Currently we tell the aged person that when he hurts he has to go to pay money to get service. This puts a disincentive in the wrong place.

We could say, on the other hand, to the primary care physician, look, we want you to give a comprehensive service and we will pay you on an annual basis for this service and any time your patient needs something additional we want your concurrence. We do not want the patient shopping, we do not want unnecessary things done and any time you hospitalize the patient, that is going to come out of the fee that we are going to pay you to keep the patient well. I think that paying a primary care physician on a capitation basis——

Mr. COHEN. How does this differ from the HMO concept?

Dr. SHINDELL. Well, the HMO concept requires an organization. This is an individual physician HMO, if you will. I want every primary care physician to act like a health maintenance person, a help maintenance purveyor, if you will.

Now, the HMO's concept is excellent in that——

Mr. COHEN. Could we stop here for a second.

How do you deal with—I am sure that a general practitioner would not have all the expertise that would be necessary to deal with some of these specific problems or illnesses that would be encountered. How do you deal with that?

Dr. SHINDELL. OK. While a family practitioner or general practitioner may not have all the expertise necessary to deal with all the problems that he might encounter, he is certainly capable of dealing with 90-plus percent, 95 percent of what he is likely to encounter. You know, most people have usual problems. Most people do not have unusual problems by definition. Now, when you do need a specialist's services the big problem we face in our current medical care system is that patients often have to make their own diagnosis, shop around for appropriate care. As a result sometimes care is given without concern for the whole person. Let me give you a case. I think this is a horrendous case, but illustrate what I am trying to say.

There was a man 78 years of age who has had progressive arteriosclerosis and diabetes and this had been going on for some time. About 4 years ago they brought him to a hospital for a complete "workup." I think most of the work that was done was totally unnecessary, but it was very extensive and was paid for by the medicaid program.

For the next couple of years he intermittently had some mild heart failure and some diet regulation, all of which was handled on an outpatient basis periodically. As he grows older and the circulation in his legs deteriorate, he begins to have some pain while walking.

He goes to a podiatrist who said, I think you are developing neurinomas between your toes. Now, there is ample evidence as you read his record that his circulation has been compromised. If there is any cardinal rule for treating a human being with diabetes and with impaired circulation, it is that you protect the feet at all costs. You protect them from trauma, that is you do anything you can to see to it that you do not have any injury because in the presence of compromised circulation like this, healing will be difficult.

Well in the case I'm relating somebody did not pay any attention to the cardinal rule and in fact the podiatrist went in and tried to remove some neurinoma and as you read the pathological report there was no neurinoma there anyway, and the rest of the story you know. The foot did not heal and eventually the man had to have an amputation.

Now we paid for an unnecessary workup because it was there to be paid for. We pay for——

Mr. COHEN. Why would you say it would be unnecessary? Would you not recommend that that workup be done in any event?

Dr. SHINDELL. Of the real workup that was done on this individual, I would say 60 percent of it was done because we had the technology to do it, not because it addressed any problem the patient had.

Mr. COHEN. Do you think that physicians are oversensitive about malpractice suits that also account for the——

Dr. SHINDELL. No, there was no acute problem here. This was a man who had been handled on an outpatient basis who was brought to the hospital for a "full" assessment because we pay for things in the hospital that we do not pay for on the outside. Over time, he could have gotten most of the similar studies selectively if his physician were oriented to give him comprehensive services extending over time. But instead we paid for about 5 or 6 days of hospitalization, a lot of which I will say I felt was unnecessary.

The most important thing though is that nobody had second-guessed the podiatrist at the time the surgery was contemplated, and as a consequence this man lost his leg. We paid for additional hospitalizations during the time the foot was not healing and then another hospitalization when the amputation was done and now we are paying for the rehabilitation services in-house. The man, of course, is suing the podiatrist for malpractice, but I also think the public ought to be suing him for the drain on the economy for performing services which were totally unnecessary.

Mr. COHEN. Basically though, going back to the HMO, that concept was devised or developed in the hope that it would catch on and do essentially what you are proposing to do on the individual basis, but it has not caught on. Any reason you might offer as to why not?

Dr. SHINDELL. Well, physicians tend to be individualists. I guess that's the best answer. Physicians, while they may work in small groups or have limited associations, tend not to want to work in large organizational settings. If you do, then you go to an academic setting or you work in a large clinic or you work in industry, or whatever. By and large, I think the group practice concept has been successful

for those people who feel that a comprehensive service is required and are willing to work in large organizations to achieve it.

But by and large, physicians tend to be entrepreneurs. This is not to be derogated totally. I think that you pay a price for everything you do. If you want somebody who can make a decision in an emergency, come hell or high water, you are going to need an individualist. Such a person is going to want to do things his way.

If you want physicians who are great committeemen, who are going to defer to everybody else's judgment and are willing to talk things over before we begin anything, then I don't know who is going to do the immediate resuscitation, and I don't know who is going to stop the bleeding, and I don't know who is going to jump in and do the kind of things that have to be done. But it takes a degree of self-confidence, to give care in an emergency and you pay a price for that capability.

I myself do not currently do clinical practice. I have great admiration for most of my colleagues who do, but I think that the average physician, as I know him across the country is a conscientious man that is trying to do a good job. I said the average, the vast majority. There are obviously colleagues whom I am ashamed of, but I think that given the opportunity to relate to a patient and to give comprehensive care, I think the physician is going to do it.

I think physicians have tended to abuse the system because the system required them to do it in order to serve their patients. If the only way you can get your patient served is to admit him to the hospital and have to justify why the admission was necessary, you are going to do it because your patient needs it.

Mr. COHEN. I am still a little bit troubled about what you are saying about the HMO's and physicians being individuals I assume that is another way of saying they have very strong egos and they don't really like to refer to other doctors or physicians, but is not referral one of the most serious deficiencies we probably have in our health delivery system?

Well, I guess you disagree with this, but many of our elderly do have chronic and multiple problems which do not lend themselves to remedy or cure.

Dr. SHINDELL. That's right; that's exactly right.

The focus has to be on treating the individual and his totality of problems rather than the specific disease here and now. If we are going to talk preventive medicine, what we are really talking about is anticipating what is going on, what is likely to go on in the future and doing what we can do today to avoid unnecessary disability, discomfort, and disease at some future time.

I think that most physicians will do this if you were willing to pay for it. If, on the other hand, the only thing you are going to pay for is a definitive workup and you are willing to pay for taking care of an acute disease problem and will pay for only that laboratory work that can be done in the hospital and only those drugs that can be gotten in the hospital, that's what physicians are going to order. People are going to find a way to use the system. What I am suggesting is that we had better revise the system. I am simply saying that today this is the only way we can arrange for the needed workup or necessary drugs or whatever, we further discourage preventive care by say-

ing to the patient that he is going to have to pay the major cost of it. It puts everybody in a dilemma.

Mr. COHEN. We find that many health policy officials think of preventive health care as something that should be reserved for children or young adults. I assume that you would state that preventive care can be beneficial and cost effective for those over 65 as well?

Dr. SHINDELL. I think it goes on throughout one's life, until the day he decides that he wants to give up.

If you want to look ahead—I don't care how far ahead—then you should really have a preventive approach to what you are doing. The day one stops looking ahead and wants to end it all, that is the time you can discontinue the preventive approach.

Mr. COHEN. One final point. Chairman Pepper and others on this committee have proposed legislation that would provide medicare coverage for physical exams. That in your opinion would be very beneficial for detecting illnesses, especially chronic illnesses among the elderly, would it not?

Dr. SHINDELL. Yes; and no.

Mr. COHEN. Let's listen to the "no."

Dr. SHINDELL. I will repeat what I said before that the real value of screening is in the followup. I also like to make clear that a health assessment and a physical exam may not be the same thing.

Now, 80 percent of what we need to know about a patient we usually find out from history, not from a physical exam or laboratory workup. To pay the money for a physical exam or for extensive laboratory work, unless it is coupled with a good historical review of the individual and a good followup system is putting out money for a definitive purpose that has a limited benefit because it only does a piece of the job. If I may make an appeal to you, it is to promote a comprehensive approach to an individual over time rather dealing solely with the here and now of a specific disease. That's where I think we ran into trouble in the first place.

Mr. COHEN. Let me just go back because I want to separate out getting a good history as opposed to the followup. I assume that if you go for a physical exam that as part of that physical exam the physician gets a history so that should not be a problem as far as getting the history, assuming the patient is cooperative and is trying to be as helpful to the doctor as possible.

The other part in which I tend to agree with you that if we stop there as far as detection then that provides a disincentive the other way in terms of the payment by the individual and we have not done much of anything other than spend a lot of time.

Dr. SHINDELL. Well, maybe I am stuck on jargon.

When we say a physical exam, to me that means something very special. A physical examination is designed to enable us to address a series of symptoms when somebody comes to a physician with a problem.

Mr. COHEN. Suppose they don't come with any health problems, what then?

Dr. SHINDELL. Then you do not do a classical physical exam because you are not looking for the corroboration of the symptoms. What you then do is what I would call a health assessment and I think a health assessment combining the right kind of history and the right

kind of studies. I would prefer not to call this a physical exam because there is very little that you need to do on a physical exam unless there is a sypmtom or unless the history indicates a hidden problem.

There are only a few things that you can find out by doing a physical exam on an individual without symptoms. Therefore, to suggest that we want to do physical exams which take 45 minutes to an hour if you do a good one is a waste of the 45 minutes to an hour. Given a health screening type of exam, one can do a health screening type physical in 5 minutes. I do not want you to pay for an hour long physical exam when a 5-minute health assessment is as effective. I would rather take the money that it would cost and spread it over the time that it would take to do a health assessment, and work with the patient on a health maintenance plan over a period of time.

I can't think the problem is the physician who will not refer. Physicians may tend to refer away a patient, in a sense give away their responsibility because there is no way today one may retain the responsibility within the current payment mechanism.

To go back to the case I indicated, the primary care physician was told by the patient that he was going to go to a podiatrist. He had nothing to say about this. He might counsel him against it, but the patient says, I'm going to go, and so the patient went. He got the operation, the wrong thing under the circumstances, but the physician who should have been able to advise him, guide his patient, was left out of the picture, and then the wrong thing was done.

Mr. COHEN. Was the podiatrist covered under medicare?

Dr. SHINDELL. Oh, sure. The cost of the surgical procedure and the hospitalization were all taken care of.

Mr. COHEN. How would that be different under your plan, I mean, if the physician could have said, Well, do not go to the podiatrist, you don't need that kind of——

Dr. SHINDELL. He could have said, I won't authorize it. I won't authorize payment for that; that's too dangerous for you to undergo.

Mr. COHEN. He could do that under your proposal but not under the current?

Dr. SHINDELL. I think that's right.

Right now we are wondering whether we should have a second opinion whenever a surgical procedure is to be done or we wait until something is done and then we have a review by a PSRO. I would like the manager, the health care manager to have the right to certify anything that goes on beyond comprehensive primary care. I would like to stop shopping around. I would like to stop unnecessary service.

Mr. COHEN. Do you think doctors would be willing to assume that responsibility?

Dr. SHINDELL. I think that there is an increasingly larger number of physicians in this country who are being trained to and would be willing to assume this responsibility.

Now, as you know, I am in preventive medicine, but I am referring to having a family practice type primary care physician serve this role, I am not looking to have new tasks assumed by preventive medicine people. I think we have enough to do. I am not out to find more business for my field. I am out to improve total practice.

Mr. COHEN. Do you not think that doctors would be awfully gun shy of assuming that total responsibility and saying, look, if you want to

get a second opinion, that's up to you and I won't certify that you shouldn't be reimbursed for it, in fact in trying to spread the risk of any potential lawsuit against him?

Dr. SHINDELL. Well, on the other hand, if you are paying a person on a long-range basis to be a health care manager, he has one other option and that is to say to the patient, "I can't continue to manage your condition. You go register with someone else because I will not assume the responsibility."

Mr. COHEN. Well, thank you very much, Doctor. Do you want to complete your statement? It will be entered in full in the record.

Dr. SHINDELL. Well, I hope it will be.

Mr. COHEN. Thank you very much.

[See appendix 2, p. 56. for Dr. Shindell's prepared statement.]

Mr. COHEN. Next is Ms. Hilda Robbins of Fort Washington, Pa. Ms. Robbins is president-elect candidate for the Mental Health Association National Headquarters and she is the former president of the Mental Health Association of Pennsylvania and current chairman of the National MHA Committee on Legislation and Services. She also served as a member of the Task Panel on Financing the President's Commission on Mental Health.

Ms. Robbins, welcome.

STATEMENT OF HILDA ROBBINS, PRESIDENT-ELECT CANDIDATE, MENTAL HEALTH ASSOCIATION-NATIONAL HEADQUARTERS, FORT WASHINGTON, PA.

Ms. ROBBINS. Thank you very much.

I certainly will not add to the comments you have already made except to say that we would want you and others to know that the National Association for Mental Health is a consumer organization. We advocate for the mentally ill, their families, and to promote mental health.

I was very pleased to hear that there is a consideration on some changes, hopefully; some deletions or restrictions have been very discriminatory to the mentally ill under medicare.

This testimony is designed to illustrate how the medicare program discriminates against one specific segment of the population, the mentally ill, and I urge the members of the committee to take the initiative in ending this discrimination.

Let me begin by quoting one sentence from an editorial in the February 1976 issue of Saturday Review. That entire issue was devoted to the mentally ill, but it seemed that Norman Cousins concluded a rather long editorial about the mentally ill and had this comment: "No other group of Americans—not blacks nor senior citizens or members of religious minorities—is more victimized by discrimination." He was referring, of course, to the mentally ill.

The discrimination of medicare against the mentally ill does not lie in its administration or in some arbitrary regulation drawn up in the vast HEW bureaucracy. The discrimination is written right into the law to title XVIII of the Social Security Act. Title XVIII is the part of the social security program, of course, as you are thoroughly familiar, that provides hospital and medical insurance.

Well, where does this discrimination lie? Under part A, hospital insurance, the beneficiary is covered for a certain number of days each time she enters the hospital. The beneficiary may return to the hospital as many times as is necessary for the rest of her life, as long as there is the break of 60 days between hospital stays, and still be covered by medicare unless she is a patient in a psychiatric hospital.

If the beneficiary is a patient in a psychiatric hospital rather than a general hospital, there is a lifetime limit of 190 days of coverage under medicare. To repeat there is no limit on the number of times the beneficiary may be treated if they have a physical illness, but there is a lifetime limit of 190 days for hospital treatment for mental illness. This is blatant discrimination against the mentally ill, and it was written into law by the U.S. Congress.

It becomes even more apparent how dreadful this is when you realize that most general hospitals or many general hospitals will not accept a psychiatric case. Moreover, if the beneficiary is a patient in a psychiatric hospital at the time that he becomes eligible for medicare the number of days he has already spent in the hospital is deducted from his initial benefit period. No such deduction is made against the patient who happens to be in a general hospital when he reaches 65 or becomes eligible.

We think that this is a totally unwarranted kind of discrimination. These inequities could be eliminated by the very simple device of striking the limitations from the law as it now stands and we urge the members of the committee, with your avowed dedication to the elderly citizens, to take the initiative and introduce legislation toward that end.

I have included, attached to my statement that you have there, the specific parts of the legislation that we are suggesting be stricken.

Now, to move on to part B, the medical insurance. This provides for those who choose to subscribe, that the Government will pay 80 percent of allowable doctor bills and related medical expenses, after a deductible of $60 per year. Once the deductible has been met there is no limit on the amount of reimbursement in any one year except for mental illness. If the diagnosis is mental illness the absolute maximum reimbursement in any one year is $250. This is gross discrimination as compared to the unlimited opportunity for health care by the physically ill.

Moreover, whereas medical bills, assuming they are reasonable and otherwise, of course, for all other illnesses are honored at face value, part B of title XVIII states that the allowable cost for the treatment of—I quote: "Mental, psychoneurotic and personality disorders shall be only 62 and a half percent of the actual cost."

What this boils down to is that for all other illnessess medicare pays 80 percent after the deductible, but for mental illness pays only 50 percent and then only up to a ceiling of $250. If the deductible bill is all for mental illness and includes no other illnesses in there, the ceiling is not even $250, it is $202 per year.

The Mental Health Association resents this cruel and arbitrary discrimination against the mentally ill and calls again, for this committee to take the lead in striking the language that is so discriminatory.

Thus far I have discussed only those limitations which were purposefully written into law. There are others, however, which although presumably unintentional are invidious. One of these is the equating of inpatient care with hospitalization as title XVIII does. Since medicare was first proposed there has evolved in this country a whole new concept for treating the mentally ill. The emphasis is away from long-term commitment to a huge remote hospital and toward quick and intensive care in small community centers.

The Congress itself has been very mindful of this in providing Federal seed money for community mental health centers and in July of 1975 Congress made this comment in voting a renewal:

> The Congress finds that community mental health care is the most effective and humane form of care for a majority of mentally ill individuals, and two, the federally funded community mental health centers have had a major impact on the improvement of mental health care and thus are a national resource to which all Americans should enjoy access.

Moreover, Congress expressed in Public Law 94–63 the requirement that every such center must—this is not an election, but—must serve the elderly as well as other age groups. Yet the very centers which Congress has helped create and which Congress has directed to serve the mentally ill are frequently not able to qualify as providers of inpatient services under medicare.

Only 58 percent of all citizens, based on the 1975 sampling of 178 centers are being reimbursed by medicare for inpatient services in community mental health centers. Of this 58 percent, 96 percent of the centers operated by hospitals are being reimbursed. Sixty seven percent of those affiliated with but not operated by our hospital are being reimbursed, but only 16 percent of the freestanding centers are being reimbursed by medicare for inpatient services.

The paradox is more striking when viewed in the light of the House report on the 1975 amendments. The report is highly critical of both HEW and the centers themselves for their poor performance in helping to finance their operations to third party payments, especially for medicare and medicaid. Although the report does recognize the problem I am describing, it has not made the necessary moves to correct it.

The paradox is even more striking when it is realized that the average cost per patient day in community health centers is considerably less than that in the average psychiatric hospital or mental hospital.

To remedy this discrimination against the elderly mentally ill we recommend that Congress amend title XVIII to recognize federally funded mental health centers and any other centers which, although not federally funded, meet the comparable standards to the satisfaction of HEW.

Another stumbling block is the provision in part B which limits reimbursement for outpatient service by clinics to those services provided only while a physician is on the premises. The physician does not have to see the patient. It is required only that he be on the premises. In the field of mental health, physicians, notably psychiatrists are but one of the many disciplines useful in combating mental illness. Others include clinical psychologists, psychiatric social workers and psychiatric nurses. Every mental health center has one or more physicians on its staff, but as often as not, while there might be as many as a

dozen licensed physicians on the staff, the physicians are part-time employees. Seldom is one on the premises around-the-clock, and the hallmark of a community health center is that it is open 24 hours a day, 7 days a week.

Additionally, many community mental health centers have developed satellite centers, branches located in outlying parts of the service area. A physician is an indispensible member of the mental health team, but he certainly cannot be in all places at all times.

May I also point out yet another aspect of discrimination against the elderly mentally ill. Most of the national health insurance bills, now pending in the Congress would incorporate either permanently or during the phasing-in period, those parts of title XVIII which we think are so discriminatory. If medicare is to be the model for some of the national health insurance legislation, then by all means first let us amend that title and wipe out the discrimination that exists against the mentally ill.

I would be remiss if I left the impression that the Federal Government alone discriminates against the mentally ill. That is not the case. While there has been tremendous improvement in the inclusion of mental health coverage in private health insurance policies in recent years, especially group policies, many private health insurance policies are still much more discriminatory than even medicare.

There was an article in the January 1976 issue of Consumer Reports, "The Medigap" and this pointed out that the insurance which takes up where medicare leaves off, 9 out of the 14 hospitals or medical insurance plans including 4 of the 5 which were promoted by the Association of Retired Persons, pay absolutely nothing if the diagnosis is mental illness. Of the seven which paid anything at all, the amounts are pathetically small, being limited in most cases to the deductible and co-insurance not paid by part B.

This concludes the formal part of my presentation. I think that you are abundantly aware that even though we are only discussing the discriminations in medicare today, there are similar discriminations in medicaid that point out the problems of the mentally ill. I think I heard you referring to some revisions on the EPSDT kind of provision for the care of children. I think the name is CHAP, child health assessment projects, and we were alarmed and are working diligently in hopes that that bill can strike what is in its proposal now that would say that States did not have to provide these services for mentally or emotionally disturbed children. So this thing of discrimination on the basis of the mentally ill is not exclusively against the elderly. It permeates everything. I think to take a bold step in saying, well, certainly we are going to stop this kind of ridiculous discrimination that has no reason as far as this large part of our population is concerned, would be a very courageous and a very useful thing for this committee to do.

Mr. COHEN. Ms. Robbins, thank you very much for your very vigorous and comprehensive statement. I have but a couple of questions.

On page 4 of your testimony you refer to the ceiling in the Federal reimbursement on medicare for mental health services as being $250 or $202 whichever the case might be. Do you know what the average cost for an elderly patient receiving mental health care would be, how many elderly fall under that ceiling?

Ms. Robbins. I do not know that right now, but I will try to get that information for you, the average cost of the people. All right.

Mr. Cohen. Also, you made reference to the 190-day limitation. Again, what would be the average length of stay for elderly individuals and how many would exceed that ceiling?

Ms. Robbins. Rather than trust my memory and I know that we have that information, I will get that back to the committee. I think that it will also be important to provide you, at the same time, with some statistics as to an indication of how much the average stay, particularly a first-time admissions has decreased over the years.

I think that when medicare was first being considered that there was a general feeling, at least by some people obviously, that elderly care for the mentally ill was primarily a situation of taking care of people who had become senile because many of our State hospitals are just filled with senile patients.

More recent attention to what is really the problem with the mentally ill indicates that many of them are depressed. They can be treated with fairly inexpensive drugs in most cases and live perfectly acceptable and fulfilling lives on the outside of a hospital and never have to go to the hospital at all. Undoubtedly that must have been part of the thinking originally, but now that we have more information about that I would hope that it could be rethought and rewritten.

Mr. Cohen. Finally, you clearly outlined a policy contradiction of a medicare reimbursement to community health centers. How has this specifically affected the utilization of the centers by the elderly?

Ms. Robbins. I think that the very fact that in the Renewal Act of 1975 there was a written mandate to take care of the elderly indicated that there was a feeling among those of us who were working on revamping that law that not enough of the elderly were being taken care of in the community health centers.

There are a lot of reasons for that, but I think that one of the reasons that is more obvious is the cost because even though it costs less to provide for a psychiatric patient in a general hospital than it does for a physically ill patient, hospitals are still reluctant to take them in. I think some centers are doing it.

Mr. Cohen. Do you have any statistics you can provide the committee with the relationship, if any, between poverty and mental illness among the elderly?

Ms. Robbins. I will ask. I am not quite sure about that. I think poverty generally, though, is considered. There is something that is called multiple unendurable stress and we know that people who have multiple unendurable stress, which would certainly apply to many elderly people, have a higher incidence of mental illness. They are out of a job, living in a poor housing situation and maybe not enough food and all of that. So I will check that out.

[See appendix 2, p. 70, for additional information supplied by Ms. Robbins.]

Mr. Cohen. Thank you very much, once again.

I want to welcome my colleague, Father Drinan, here. Although I was in need of rescue, I was not sure it had to be from the brotherly side of the aisle. But thank you for attending this hearing. I will turn the meeting——

Mr. DRINAN. No; if the gentleman would just continue; he is doing so well. I will listen and learn.

[See appendix 2, p. 59, for Ms. Robbins prepared statement.]

Mr. COHEN. Our next witness is Sammy Griffin, who is president of the National Federation of Licensed Practical Nurses, and he is executive director of the North Carolina Licensed Practical Nurses Association, and a licensed practical nurse himself. Welcome Mr. Griffin.

STATEMENT OF SAMMY GRIFFIN, PRESIDENT, NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, EXECUTIVE DIRECTOR, NORTH CAROLINA LICENSED PRACTICAL NURSES ASSOCIATION

Mr. GRIFFIN. Thank you, Mr. Chairman. Since you have already introduced me, I would like to reemphasize however, that I am a licensed practical nurse.

Mr. Chairman, our national organization recently held its annual convention in Miami during the first of this month. Although Congressman Pepper was scheduled to be our keynote speaker, his plane was unavoidably detained in Iceland, but we greatly appreciated his thoughtfulness in sending his very able staff director, Bob Weiner, to represent him. His keynote address to the nearly 2,000 present at that evening's ceremonies was both inspiring and informative. We were impressed by his knowledge of his subject matter and his dedication to the committee and its important work.

The National Federation of Licensed Practical Nurses is the professional organization of licensed practical nurses and exclusively comprised of licensed practical nurses.

Presently there are approximately 600,000 licensed practical nurses throughout the country who are an integral part of the health care team. As the Nation's second largest group of health providers, licensed practical nurses play a vital role in the delivery of health care services, and because we provide these services in a wide range of settings, we are keenly aware of our Nation's health needs.

One such area where we find present health care services inadequate is for our senior citizens. Besides the staggering statistics of spiraling costs and increasing numbers of people who reached their sixties and who can neither afford nor find adequate health care services is the human suffering and the loss of personal pride and dignity because of these inadequacies.

As the bedside nurse, we see the needless suffering by many patients.

Of major concern to us is that we perceive a great inability on the part of America to provide adequate health care delivery. The prime reason for this is the underutilization of health care providers and an outdated philosophy that medical care is synonomous with health care.

The National Federation of Licensed Practical Nurses sees the necessity to distinguish between medical care and health care. It is our convention that health care encompasses a broad range of services designed to maintain the physical, mental, and social well-being of people.

There is no one profession or discipline which can do all of this and if we are to provide the proper planning, delivery, and evaluation of health care, if we are to provide a truly comprehensive health care

program which will include preventive, diagnostic, therapuetic, and restorative or maintenance care, we must use all qualified health providers and produce a system which is both effective and economical.

The burden of providing such care should not fall on one group of providers, but rather many different disciplines who are skilled and educationally prepared to offer a wide range of services.

As the Nation's second largest group of health providers, we are painfully aware of Federal and State policies and programs which encourage participation of only a few professions in the delivery of health care services. We see an urgent need to reverse the policies and programs and fully utilize not only licensed practical nurses, but other qualified health providers.

These policies greatly affect the cost and quality of present health care programs and waste valuable resources. Specifically, I would like to address myself to three areas of deficiencies in the current medicare program which, because of these requirements, greatly impair the delivery of health care services.

One: Present medicare regulations prohibit and discourage alternatives to institutional care because of their skilled nursing requirements.

Two: Present medicare requirements which limit the number of home health care visits to 100.

Three: Present medicare requirements which mandate prior hospitalization before an individual becomes eligible for home health care services.

We see these requirements as needless and costly barriers which prevent low cost quality health care delivery.

The inadequate utilization of home health care benefits is due primarily to the medicare requirement for skilled nursing care. The Government has selected a series of medically oriented tasks and observations and defined them as "skilled" care and limited reimbursement eligibility to these tasks, thereby eliminating many preventive and maintenance services needed to keep the elderly out of hospitals and other institutions.

An elderly widow in North Carolina who was weak and palsied needed certain eye medication administered on a daily basis, but because of her infirmities she could not administer the medication herself. Though the actual giving of the medication would take less than 1 minute, as the result of such impractical regulations, medicare did not pay for the services because it was not termed "skilled" nursing care.

Clearly, one could see that this artificial and unnecessary requirement for reimbursement severely impairs the ability of licensed practical nurses and others to provide needed services.

Similarly, 600,000 licensed practical nurses who are educationally prepared to do many of the same tasks as the registered nurse cannot provide that service because of the use of the word "skilled."

We want to emphasize a point here, Mr. Chairman, that the thrust of our argument in no way lessens the quality of care, but merely utilizes more effectively and efficiently those practioners who have been educationally prepared.

What is particularly encouraging about the full utilization of health care practioners is that it will eventually enable more people to enter

the delivery system. We feel that this action in the long run will encourage greater use of home health benefits and reduce dependency on more costly institutional care.

Congress has just recently recognized that some medicare and medicaid policies are too restrictive and prevent the utilization of many health care providers. The rural health clinic bill establishes a more multileveled and multidisciplined approach where health services would be provided by practitioners other than physicians. We think that this is a step in the right direction and should be expanded to include licensed practical nurses and other qualified health providers.

The second area of professional concern to us regarding the limitations in the present medicare program is that present requirements limit the number of home health visits to 100. This restriction, too, prevents the needed delivery of health care on a need basis and becomes costly when the maximum home visits are used and institutionalization is required.

Many elderly people are prone to chronic long-term illnesses and the 100 visit limitations under parts A and B of medicare expire before the patient has had sufficient opportunity to recover. Unlimited home health care would also discourage the use of hospitals and institutions and would provide a more familiar and welcome convalescent place to an elderly individual.

Also, through the expanded role of such health providers as licensed practical nurses in a situation where home health visits would be unlimited, preventive and diagnostic services could be delivered and perhaps save a patient from becoming ill, save money as well, and spare the patient possible hospitalization. We do know that it costs less to prevent an illness than it does to treat it.

It is in these areas that new and expanding roles for registered nurses, licensed practical nurses and other providers can help keep people out of hospitals, yet provide them with quality care. We must add at this point, however, that the unlimited use of home health visits should be closely tied to an effective utilization review program and that this review mechanism should be developed and administered by representatives of all of the providers rendering service.

Our third area of concern is that the present medicare requirements which mandate prior hospitalization before an individual becomes eligible for home health services are too costly. Last spring we learned that each day American taxpayers pay $48 million for hospital care under medicare-medicaid.

The Department of Health, Education, and Welfare estimateed that in the fiscal year 1976, the medicare program spent more than 75 percent of its funds for hospitals and nursing home care. They report that in 1976, $55 billion was spent on hospital care alone and that if present trends continue, total spending on hospital care in 1986—just 9 years from now—will be a staggering $220 billion.

Many times, in an effort to assist a patient in receiving needed benefits, physicians will unnecessarily admit a patient to the hospital so that the patient will be eligible for home health or nursing home care. We see that not only is this costly, but it causes a physician to choose between properly treating his patient or complying with the law.

In addressing these three areas, we hope that we have been helpful to the committee in pointing out glaring gaps in medicare which impact on the quality of health care delivery as well as the cost. Needless to say, we all have a stake in the system which now treats our elderly.

In our desire to provide necessary health services, we must constantly evaluate the present system, correct its glaring deficiencies and inefficiencies and remember that our goal is to maximize health care delivery services and minimize costs. We suggest that the three medicare regulations discussed here today impede the progress, the process and keep us from our goal.

This committee has traditionally been one of the leaders in articulating the health needs of our citizens, especially the elderly. We applaud your efforts and are proud to work with you, and we eagerly await the day when all those in need of health care are able to receive the best care at a reasonable cost. Thank you.

Mr. COHEN. Thank you very much, Mr. Griffin, for your testimony. I have just a few questions I would like to ask.

In your testimony you have outlined the limitations imposed by the so-called skilled requirement. What skilled services are licensed practical nurses trained to perform?

Mr. GRIFFIN. Such skilled requirements as treating wounds, doing wound dressings, certain diagnostic procedures such as oscillating the heart and lung sounds, the administering of medications and we interpret electrocardiogram rhythm strips. We also test reflexes, the venipunctures for intravenous injections, and help in active and passive exercises, for example.

Mr. COHEN. Do you think there should be a distinction between—well there is obviously a distinction between registered nurses and LPN's in terms of the types of services that they can and cannot perform. Do you think that distinction is not a valid one?

Mr. GRIFFIN. It is a valid distinction. In a few areas registered nurses can provide services that licensed practical nurses cannot; however, each level of nursing provides preventive diagnostic, therapeutic, restorative, and maintenance services, and both LPN's and RN's are a part of nursing care.

Mr. COHEN. Do you think that professional accreditation should be limited to academic achievement or would you favor some sort of proficiency test? I notice on page 5, I think, you used the words "educationally prepared." What do you mean by that?

Mr. GRIFFIN. The educational preparation, the curriculum that the nurses have taken.

Mr. COHEN. Well, again, would you limit it to the academic training or to proficiency tests?

Mr. GRIFFIN. Academic training and proficiency tests.

Mr. COHEN. I would like to just point out, I will ask you a question pertaining to my own State of Maine, how many people in Maine would benefit from home health services of LPN's if the skill requirement were deleted and then how many nationally?

Mr. GRIFFIN. Approximately 100,000 in Maine. Nationally the figures are more dramatic. There are more than 23 million people over 65 and probably 2¼ million people who are disabled. Actually it would be 10 million people who would benefit by home health services.

Mr. COHEN. Thank you. At this time I would like to yield to a good friend of mine who I served with not only on this committee, but also the House Judiciary Committee and I frequently, during our public sessions, yield to what I call a higher authority.

Mr. DRINAN. Thank you very much, Congressman Cohen.

I want to commend you, Mr. President, on this statement, and I am happy to know that the licensed practical nurses are so well organized under your able leadership.

On page 7 you state that many times a physician has only one option and he will unnecessarily admit a patient to a hospital so that the patient will be eligible for home health or nursing home care. Are there any statistics on this where doctors say this is the only avenue open to them?

Mr. GRIFFIN. I am not sure there are statistics available——

Mr. DRINAN. Well, we could get the actual admission count, but physicians simply state that it was their judgment to admit the patient and I don't think they openly admit that this is the only way by which they can see that their patient is eligible for home health or nursing home care. It would help us and if you have any statistics, any survey where this was the only reason, I am certain that Mr. Califano would want to know, because as you know he talks every day about this escalating cost and he refers to millions and billions of dollars which seem preposterous, but perhaps that is really so.

Now, the bill that we passed yesterday you make reference to, the rural health clinics. Would that in part cure the difficulties that you are talking about?

Mr. GRIFFIN. I think in part it would, sir. The bill passed yesterday refers to nurse practitioners. LPN's and most RN's are not nurse practitioners but the idea that providers deliver services which they are prepared to do is the thrust of our argument.

Mr. DRINAN. Well, I just went back over the bill that passed. Tell me again how it would because I do not quite see it as a full solution, at least, to the department that you are in.

Mr. GRIFFIN. Again, because rural health settings lack a physician or RN, the licensed practical nurses could provide services to the patients who are in need of better health care delivery. Also, they would benefit from the treatments and diagnostic procedures that would be offered by a licensed practical nurse.

Mr. DRINAN. The bill that we passed yesterday speaks of nurse practitioners and physician assistants as defined in the various States. Reimbursement can be made only in those States which authorize nurse practitioners and physician assistants to provide medical services.

Mr. GRIFFIN. That's correct. Again, LPN's and most RN's are not nurse practitioners but they can provide nursing services.

Mr. DRINAN. About how many States would allow that?

Mr. GRIFFIN. I am not sure of the number of States.

Mr. DRINAN. But a bill along this line would in fact cure the problems that you are talking about?

Mr. GRIFFIN. Yes, sir. The concept of better utilization of health care provisions is the point of my discussion today.

Mr. DRINAN. I am sorry that the committee was not able to reach the problems that you have because this seemed like an attractive

bill, bringing medicare and medicaid to those rural clinics which because of these rules had been up to now precluded from them.

I commend you on your statement in that it is very clear and I see what you are doing. Now, these rules, the 100th rule has been the basis of an appeal made to HEW to get rid of it. Has there been hearing conducted on that by HEW—that was established by HEW and not the Congress.

Mr. GRIFFIN. There have been.

Mr. DRINAN. With what result?

Mr. GRIFFIN. Nothing as of yet.

Mr. DRINAN. I suppose the Congress could set it aside, but I think the Congress would be a little reluctant to change or just wipe out the 100 and let it be infinitive. Legislation I know is pending, but this is a serious thing day-by-day for you people.

Once again, on the origin of that rule that a person simply has to go to a hospital before that person can get home health care, who made that up and why? Once again, there must have been hearings recently and why do they not repeal it?

Mr. GRIFFIN. I am not really sure. I would imagine it would be HEW.

Mr. DRINAN. Well, was there some attempt to forbid fraud? It does not seem, on the fact of it, to really make sense that one has to go to a hospital before one can have home health care. Was the provision put in there so people would not be getting home health care when actually they did not need it? Did they actually want to get a hospital record indicating that this person was seriously ill?

Mr. GRIFFIN. I really can't answer that because I really don't know, but I imagine it is part of the antiquated philosophy that the only people who need health care services are those who need institutional care.

Mr. DRINAN. All right. I thank you once again and I yield back to my friend from Maine.

Mr. COHEN. I would just mention or say that I assume the rationale behind the limitation is that as we have been witnessing fraud and abuse of medicare and medicaid. In fact, we just passed an amendment to the Medicare-Medicaid Act to try and correct some of those abuses.

I was going to mention that we should not allow this hearing to be closed with the notion that this is going to be a vast saving in money for the American people as far as health care is concerned. Now, you referred to the figure $220 billion by 1986 and point to home health care as an alternative of reducing that skyrocketing cost. The fact of the matter is that while there may be some savings in terms of providing quality care, home health care, the fact is you will have more people who will be serviced by that quality of home health care which will probably more than offset the savings you have with limited amount of people who are now getting care in hospitals. So whether there will be any net savings to the American people is still a question. We hope to have a better health delivery system and a better quality of care for all Americans. That really is our objective, so I do not think we should delude ourselves into thinking we are going to save a lot of money.

Mr. DRINAN. No; but if the gentleman would yield, I think this would prevent the institutionalization of a number of elderly people and that would save tremendous amounts of money.

Mr. COHEN. The other point is that I think before we really turn our attention, full attention, to home health care that we ought to adopt the bill which I introduced which is called the "Home Health Care Standards Act," which is designed to prevent the same types of abuses we have seen in medicaid before we expand the program and not afterwards.

Mr. DRINAN. I have no additional questions. I want to thank you once again, Mr. Griffin, for your testimony.

Mr. GRIFFIN. Thank you.

[See appendix 2, p. 71 for Mr. Griffin's prepared statement.]

Mr. COHEN. Our next and final witness is Mr. Stephen Sund of Putnam County New York. He is founder and former president of the Putnam Valley Senior Citizens, Inc., cofounder of the Mid-Hudson Region Association; member of the board of the New York State Chapter of the National Council of Senior Citizens. He was a participant in the White House Conference on Aging in 1971, and he is a member of a number of other organizations. Mr. Sund, thank you for your patience. You have been waiting here this morning and we welcome you here today.

STATEMENT OF STEPHEN SUND, PUTNAM COUNTY, N.Y.

Mr. SUND. Thank you very much.

According to the medicare law, after a deductible of $60, medicare is supposed to pay 80 percent of the "reasonable" fee of a doctor. However, what the doctor finds reasonable and what medicare finds reasonable often varies as much as 70 percent. This means that instead of paying 20 percent of the bill, the elderly person must pay between 65 and 75 percent and the result is often financial catastrophe.

There are cases where the doctor's fee amounts to more than $3,000. For instance, for a hip operation medicare pays $1,000, leaving the patient with a difference of $2,000 to pay out of his own pocket.

Other supplemental insurance companies, such as Blue Cross, base their reimbursement schedules on the same outdated fee schedule as medicare, which is 2 or 3 years behind the inflation spiral. Insurance companies advertise that for senior citizens who are covered by medicare for 80 percent of their bills, they will pay, for an additional premium, the other 20 percent so that the elderly will be 100 percent covered.

The actual situation, however, is otherwise. For instance, a compound leg fracture, the doctor's fee was $1,050, but medicare recognized only $244.16. An elderly woman, who had been paying $7 per month to the Blue Cross Senior Care for additional insurance received 20 percent of the $244 which amounted to $48. Despite having the additional insurance that was supposed to give her 100 percent protection, this woman had to pay $757.84 out of her own resources.

There is another case pending where the doctor sent his patient to the Lahey Clinic in Boston because he could not find the cause of her deteriorating health. The bill came to $575.50 in May 1977. She received $22 from medicare for this bill credited to the original $60 deductible.

When I myself had a serious accident to my hand from using a table saw, I was brought to a nearby doctor as an emergency case bleeding

dangerously. The doctor, who had about 20 patients waiting, sent them all home. He put me on the operating table, administered anesthesia, gave me a tetanus shot and operated for nearly 2 hours to repair the hand. I had to visit the doctor frequently for the next 2 weeks for changes of dressing, for therapy and for instruction on the exercise of the hand.

The charge for this operation and subsequent treatment was $255, which was most reasonable. I received medicare reimbursement of $70.40 and an additional $19.20 after lodging a complaint. This reimbursement was exactly 30 percent of a reasonable fee and I had to pay $165.40 out of my pocket.

These serious shortcomings in medicare coverage can lead to financial catastrophe for the elderly. It may even become a question of life and death.

I knew a woman who suffered from occasional depression due to hypoglycemia. One day she visited me in desperate straits telling me she had medical bills amounting to $800, which had to be paid out of her own pocket, despite medicare coverage. She and her husband had a combined income of $400 a month. She was in a bewildered and desperate condition. My wife and I tried to comfort her and promised to help her in any possible way. Two nights later, she went to a neighboring lake, arranged her clothes neatly and jumped into the lake and drowned.

A man, another case who had a stroke, was dependent upon his wife both physically and mentally. Without going into details, medical bills were soaring daily because of the continuous underpayment by medicare. Following a complaint, the wife was told that she could have a hearing in New York City, which is 50 miles away. She could not leave her husband for an entire day, which going to the hearing would require, because she could not afford a sitter for her husband, and moreover, he could not stay with a stranger. Therefore, such a hearing was of no help to someone living so far from the city.

I received a frantic call from her one night and went to her immediately. She was extremely agitated and said she could not carry on any longer because of the increasing pressure of medical bills. I had no idea how to help her and tried to quiet her down. The following morning she was found to have suffered a stroke and was rushed to the hospital where she died the same day.

I believe strongly, as does everybody else concerned, that there may have been a link between the grievances caused by underpayment of the medicare and the death of the people. I do not wish to overdramatize, but I do want to point out that only the smallest percentage of these grievances actually become known. If some dozens of these cases have come to my attention, how much more widespread this problem may be.

My suggestion would be as follows: to arrange for the medicare carrier and the doctors' representatives to meet periodically and regionally to settle on a uniform fee schedule. This would alleviate the problems for the senior citizens, the problems for the doctors and the relief of backlogs on payments and complaints to the medicare carrier.

Furthermore, this uniform fee schedule would become the basis for medicare, medicaid, and private insurance carriers. Last but not least,

99-337—78——5

it would save the aging from financial catastrophe sometimes leading to becoming welfare cases.

My suggestion would be as follows: periodic voluntary meetings between the medicare carrier and doctors' representatives on a regional basis to establish a uniform fee schedule. Thank you.

Mr. COHEN. Thank you very much, Mr. Sund.

I just have a couple of questions. I want to commend you on your very moving testimony and for giving us some concrete examples of the great gaps that we have in our medicare coverage and the people we are suppose to be serving.

Medicare requires certain premiums, copayments and deductibles. Do you have any idea which of these out-of-pocket costs are the most burdensome to the elderly or the public?

Mr. SUND. Generally speaking the basic problem is: One; medicare has a rating system similar to Dunn & Bradstreet which covers companies and business, for doctors. The doctor on Fifth Avenue in New York City gets the double and sometimes the triple fee of a doctor who is situated in Westchester County or if he is located just over a little bridge in Putnam County, he gets 10 percent to 15 percent less reimbursed.

Two: Even in the same vicinity the approved fees vary from one doctor to the other one. Sometimes the difference can be 50 percent.

Mr. COHEN. Are you aware, Mr. Sund, of any other emergency assistance for those people who have these serious medical problems and high medical bills and become depressed and commit suicide as you have indicated?

Mr. SUND. I would not say they commit suicide, but it does cause death. There is a link between it. There is no emergency assistance and therefore it becomes a financial catastrophe and a mental problem. I noticed this week, that an elderly was treated and charged with $250 by the doctor. According to the old schedule from medicare, this was the correct fee, but medicare allowed only $100. Medicare administration in New York City (Blue Cross) has the newest computerized equipment and my observation was, that the operators cannot handle it correctly, and are indifferent to the elderly. A complaint gets an answer, sometimes after months, in a form letter which has no connection to the complaint.

Mr. COHEN. What I was asking is, in New York for example, are there any programs designed to fill the gap between the existing medicare coverage and the types of bills that people encounter so that would lessen the burden?

Mr. SUND. Yes, there is an additional co-insurance—Blue Cross—which is also the medicare carrier. The monthly premium is approximately $7.50 per person and they promised to pay the 20 percent which is not covered above the 80 percent of medicare. Normally the senior citizens are thinking with the additional coverage they are fully insured, which is not the case. As an example: there is a complaint pending, where a woman had a bill of $1,000 and only $240 was recognized and approved by medicare, Blue Cross paid 20 percent of the $240 and the woman received $48, so she still had to pay over $700 out of her own pocket. Other insurances, such as AARP—Penn Insurance—and many others work the same way and therefore do not give any relief for senior citizens.

Mr. COHEN. Thank you very much.

Mr. Drinan?

Mr. DRINAN. Thank you, Mr. Chairman. Thank you, Mr. Sund for your testimony.

Would you elaborate on the case of the patient who went to the Lahey Clinic in your testimony. I do not understand the reason for the gap in the coverage. This patient paid $575 to the Lahey Clinic and he received only $22 from medicare credited to the original $60 deductible.

Mr. SUND. I have this case right with me if you will give me just a minute.

Mr. DRINAN. What was lacking in the coverage? There was obviously something.

Mr. SUND. I believe, from my own experiences, that this case falls under what I call bad management, which I mentioned before, but specifically if there are involved two different medicaid centers, as in this case, Massachusetts and New York City, then New York City had to pay but Massachusetts had to handle it.

Mr. DRINAN. OK, sir. If it is an administrative mixup I am not sure that we can do that much about it right now, but——

Mr. SUND. If you are interested here is an answer from September 19.

Mr. DRINAN. All right, let me see that afterward, but I was just looking for something that is faulty in the regulations or in the law itself that allows this to happen to this person.

Mr. SUND. Can I make a short comment?

The question is, No. 1, this schedule is from 1974. Doctors charge from 1977. Second, medicare does not always use this schedule that adjusts the schedule downward.

The third point is medicare management is insufficient or it is bad. Those are the three points. The main point is that the schedule is over aged.

Mr. DRINAN. All right, thank you for that explanation, and I commend to you a statement prepared by the Library of Congress called "The Aged and Their Health Expenditures," section 3 of which makes recommendations precisely about these cases where the coverage of medicare and the regulations concerning medicaid should be expanded. You will see from this that we are very conscious of the problem that you have brought to us in a very dramatic way and I am very grateful for your testimony.

Mr. COHEN. Thank you again, Mr. Sund. That concludes this morning's session. The committeewill now stand adjourned.

[Whereupon, the hearing was adjourned at 12 noon.]

Appendix 1

The Aged and Their Health Expenditures

INTRODUCTION

The following report examines the role that the Medicare and Medicaid programs have played in providing protection against the health care costs of the elderly. Chapter I of this discussion examines the perceived health care needs of the aged in the early 1960's and the response of the Congress to these needs with the enactment of the Social Security Amendments of 1965. What Congress thought these programs could and would accomplish at the time of enactment is also indicated. Chapter II details the elderly's 10-year experience with Medicare and Medicaid in the light of rapidly increasing health care costs. Finally, Chapter III suggests options for improving the protection provided the elderly through the Medicare and Medicaid programs.

I. THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS

Prior to the enactment in 1965 of legislation establishing the Medicare and Medicaid programs, Congress had actively considered for several years legislative proposals to provide hospital insurance and related health benefits as part of the social security system. Bills were introduced and hearings were conducted on the problem of meeting the health care costs of the elderly.

In September 1960, a new program of medical assistance for the aged, often referred to as the "Kerr-Mills" program, was enacted as part of H.R. 12580 (P.L. 86–778). This program made Federal matching grants available to the States to help finance programs of medical assistance for those elderly who did not receive old-age assistance payments but who could not afford necessary medical care. The legislation also provided increased Federal grants to the States to help furnish more nearly adequate medical aid to old-age assistance recipients.

A proposal for hospital insurance for the aged under the Social Security Act became part of the Administration's legislative program after 1960. Bills were introduced in the House and the Senate proposing similar programs of hospital insurance for the aged.

The health care needs of the aged in the early 1960's were documented by the President in his Special Message on the Elderly Citizens of Our Nation (February 21, 1963):

> The elderly are sick more frequently and for more prolonged periods than the rest of the population. Of every 100 persons age 65 or over, 80 suffer some kind of chronic ailment, 10 impaired vision, and 17 have hearing impairments. Sixteen are hospitalized one or more times annually.
>
> The elderly require three times as many days of hospital care every year as persons under the age of 65, yet only half of those 65 and over have any kind of health insurance; only one-third of those with incomes under $2,000 a year have such health insurance; only one-third of those age 75 and over have such insurance; and it has been estimated that 10 to 15 percent of the health costs of older people are reimbursed by insurance.
>
> The cost of hospital care—now averaging more than $35 a day, nearly four times as high as in 1946—has risen much faster than the retired worker's ability to pay for that care.
>
> Illness strikes most often and with its greatest severity at the time in life when incomes are most limited; and millions of our older citizens cannot afford $35 a day in hospital costs. Half of the retired have almost no income other than their social security payments—averaging $70 a month per person—and they have little in the way of savings. One-third of the aged family units have less than $100 in liquid assets. One short hospital stay may be manageable for many older persons, with the help of family and savings; but the second—and the average person can expect two or three hospital stays

after age 65—may well mean destitution, public or private charity, or the alternative of suffering in silence. For these citizens, the miracles of medical science mean little.

The cost of broad health insurance coverage for an aged couple, when such coverage is available, is more than $400 a year—about one-sixth of the total income of an average older couple.

Of the total aged population discharged from hospitals, 49 percent have no hospital insurance at all and only 30 percent have as much as three-fourths of their bills paid by insurance plans.

These were the problems and needs that Congress sought to address when in 1965 it passed the Social Security Amendments of 1965, P.L. 89-97, and thereby established the Medicare and Medicaid programs. The House report on this legislation states that Congress attempted to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing—

(1) A basic plan providing protection against the costs of hospital and related care financed through a separate payroll tax and separate trust fund;

(2) A voluntary "supplemntary" plan providing payments for physicians' and other medical and health services financed through small monthly premiums by individual participants, matched equally by Federal Government revenue contributions; and

(3) A greatly expanded medical assistance program for the needy and medically needy which would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children under a uniform program and matching formula in a single new title.

Medicare

As finally enacted, the Medicare program contained two parts: a hospital insurance program (Part A) and a supplementary medical insurance plan (Part B).

The hospital insurance program provided protection against the costs of inpatient hospital services, post-hospital extended care, post-hospital home health services, and outpatient hospital diagnostic services for beneficiaries under the social security and railroad retirement systems when they reach age 65. Each of these benefits was accompanied by deductibles and/or coinsurance payments by which the beneficiary shared in the costs of health services provided. Limitations in covered services were specified. In addition, Congress included provision for increases in deductible amounts for inpatient hospital and outpatient hospital diagnostic services to keep pace with increases in hospital costs.

Benefits under the hospital insurance Part A program first became available on July 1, 1966, except for services in extended-care facilities, which became available January 1, 1967. At this time, benefits and their deductibles and coinsurance rates included the following:

(1) Inpatient hospital services for a maximum of 90 days in each spell of illness. The patient paid a deductible amount of $40 for the first 60 days, plus a coinsurance payment of $10 a day for each day in excess of 60 during each spell of illness. Covered hospital services included almost all those ordinarily furnished by a hospital to its inpatients. Inpatient psychiatric hospital services were covered, but a lifetime limitation of 190 days was imposed.

(2) Post-hospital extended care (in a qualified facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients and meeting certain other requirements) after the patient was transferred from a hospital (after at least a three-day stay) for a maximum of 100 days in each spell of illness. After the first 20 days of care, the patient paid $5 a day for the remaining 80 days of extended care in a spell of illness.

(3) Outpatient hospital diagnostic services, with the patient paying a $20 deductible amount and making a 20-percent coinsurance payment for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period).

(4) Post-hospital home health services for as many as 100 visits, after discharge from a hospital (after at least a three-day stay) or from an extended care facility and before the beginning of a new spell of illness. The person must be in the care of a physician and under a plan calling for such services that was established by a physician within 14 days of the patient's discharge, and the services must be provided by a qualified home health agency. These covered services

included intermittent nursing care and physical therapy. The patient must be homebound except that payment may be made for services furnished at a hospital or extended care facility or rehabilitation center that requires the use of equipment that cannot ordinarily be taken to the patient's home.

This hospital insurance plan was supplemented by a voluntary medical insurance plan available to all persons aged 65 and over who paid a premium of $3 a month (matched by a contribution from Federal general revenues equal to the aggregate premiums paid by enrollees). This medical insurance plan (Part B) was intended to provide protection against the costs of physicians' services, home health services, and numerous other medical and health services in and out of medical institutions. When benefits first became available July 1, 1966, the plan covered 80 percent of the reasonable costs of or the reasonable charges for (above an annual deductible of $50) the following services:

(1) Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home, or elsewhere.

(2) Home health services under an approved plan (with no requirement of earlier hospitalization) for a maximum of 100 visits during each calendar year.

(3) Diagnostic X-ray and laboratory tests, and other diagnostic tests.

(4) X-ray, radium, and radioactive isotope therapy.

(5) Ambulance services.

(6) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home; prosthetic devices (other than dental) that replace all or part of an internal body organ; and braces and artificial legs, arms, eyes, etc.

In addition, a special limitation was specified for outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year was limited to $250 or 50 percent of the expenses, whichever is smaller.

Provision was included for the Secretary to adjust the premium amounts supporting the program if medical or other costs rose, and increases would be made not more often than every two years after 1968.

With the enactment of Medicare legislation, "the combined coverage of two insurance plans would result in protection for the elderly of a quality that only a few older people can now afford. Most elderly people could be expected to have the protection of both of these insurance programs. The provision of insurance against the covered costs could encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged." (H. Rept. No. 213, March 29, 1965, p. 2.)

Medicaid

As noted above, Congress sought in the Social Security Amendments of 1965 to provide a coordinated approach for health insurance and medical care for the aged and in so doing, greatly revised and expanded the medical assistance program for the needy and medically needy by establishing a new Title XIX of the Social Security Act.

The House Committee on Ways and Means in their 1965 Report on this legislation concluded that:

"The overall national problem of adequate medical care for the aged has not been met to the extent desired under existing (Kerr-Mills) legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required."

Prior to the enactment of Medicaid legislation, the State had to provide "some institutional and noninstitutional care" under the program of medical assistance for the aged. There were no minimum benefit requirements with respect to vendor medical payments under the other public assistance programs. For the new Medicaid program, a State was required to provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services for individuals aged 21 and over, and physicians' services (whether furnished in the office, the patient's home, a hospital, or a skilled nursing home) in order to receive Federal assistance for Medicaid vendor payments. Other items of medical service could be covered at option by the States.

The new law improved accessibility of the needy elderly to health care services by requiring that the States establish a flexible income test that takes into ac-

count medical expenses; the State could not set up rigid income standards that arbitrarily denied assistance to persons with large medical bills. In the same spirit the law provided that no deductible, cost-sharing, or similar charge could be imposed by the State for hospitalization under its program and that such a charge on other medical services must be reasonably related to the recipient's income or resources. In addition, the new Medicaid program required that elderly needy recipients under the State programs must be provided assistance to meet the deductibles imposed by the new hospital insurance Part A Medicare program.

The Federal share of medical assistance expenditures under the new program was to be determined by a uniform formula, with no maximum on the amount of expenditures subject to participation. The Federal share was specified to vary in relation to a State's per capita income. As a minimum, the Federal Government would pay 50 percent of the medical assistance costs incurred by a State in providing health care under a Medicaid program. In the lower per capita income States, the Federal share of medical assistance payments could increase to 83 percent.

It should be noted, in conclusion, that while the new Medicare and Medicaid programs were expected to provide protection against health care costs for nearly all aged persons in the nation, neither the Congress nor the Administration assumed that these programs would provide totally comprehensive coverage for the health care costs of the elderly. At hearings held in 1965 when the Administration offered testimony in support of a legislative proposal very similar to that which was ultimately enacted in the form of Medicare and Medicaid, the Secretary of Health, Education, and Welfare stated:

"While neither private insurance nor public assistance, alone or together, can meet the pressing need the aged have for protection against the cost of expensive illness, the proposed program contemplates an important role for both. The proposed program will serve as a foundation on which people can build greater protection through private health insurance and employer retirement plans, just as the present social security cash benefit system is serving as a base on which people build additional protection through private means.

"With basic protection furnished under social security, and taking into account the role of private insurance, public assistance will be able to assume the role most appropriate for it—that of a program intended for members of the relatively small group whose hospital needs and circumstances are such that they are unable to meet their health costs through a combination of social and private insurance and individual savings."

The House Report on the Social Security Amendments detailed exclusions from coverage under the proposed Medicare program (p. 41, 42). In addition, a House Ways and Means Committee print prepared for the consideration of the subject of medical care for the aged (July 1, 1964) indicates concern by the Committee that a social security hospital insurance program might be expanded to cover all health services for the aged and in so doing might drain off funds which would otherwise be used to maintain a reasonable level of cash benefits. The Department, in a written response to the Committee's question, emphasized the need for insurance protection against nonbudgetable health care costs (Exhibit No. 12; April 23, 1964):

"While, as the chairman pointed out, the benefits under the hospital insurance proposal cover only a part of the health costs of the aged, there is no reason to provide health insurance against all the remaining costs—aspirin, liniment, band-aids, hearing aid batteries, dental care, etc.—any more than there is reason to insure against the cost of new shoes. It is the nonbudgetable type of expenditure that requires insurance; the budgetable types can and should be provided for through cash income. The nonbudgetable types of health costs amount to no more than two-thirds of the total and realistically may be about 50 percent, which is the level of the most comprehensive health insurance now provided in the United States. . . .".

II. THE ELDERLY'S EXPERIENCE WITH MEDICARE AND MEDICAID

A. The health care expenditures of the elderly

Since the enactment of the Medicare and Medicaid programs, the cost of health care has become a major problem. Public and private spending for health care services, medical facility construction, research, and other health expenditures increased from $39 billion in 1966 to $118.5 billion in 1975. Approximately 90 percent of the 1975 health spending was for personal health care services. Health

spending, which accounted for less than 6 percent of the nation's gross national product in 1966, now accounts for 8.3 percent, and it is estimated that it will represent 10 percent of the national output by 1980.

Increased spending for health care is due to a number of factors. During the 1966–75 period, 9 percent of the increase was due to population growth. Thirty-eight percent of the increase could be explained by greater utilization of health care services and improvements in the quality of care delivered. However, more than half of the increase in health care spending during 1966–75 was due simply to higher prices. Health care prices increased about 50 percent faster than other prices during the period except when the Economic Stabilization Program controls were in effect. Rapidly escalating prices for health care services have special implications for the nation's elderly. For the demand for health care services by the aged as the result of their greater relative needs has not changed since Congress considered and enacted Medicare and Medicaid legislation.

In 1975, persons aged 65 and over were only about one-fifth as numerous as those aged 19–64, but their total personal health care expenditures were more than half as large as those of persons aged 19–64. These figures reflect the more frequent illnesses of the aged and the greater expenses involved in their care, which occurs primarily in a hospital setting. Aged persons are more than four times as likely to have their activity limited by chronic health conditions than are those under age 65. The aged are hospitalized at two and a half times the rate for persons under age 65, and their average length of stay is almost twice that of other persons.

Personal health care expenditures for the nation as a whole were nearly 15 percent higher in fiscal year 1975 than in 1974. As Table 1 demonstrates, the fastest growth occurred in spending for the aged, whose 18 percent rate of increase in expenditures was a third higher than that for the intermediate age group and half again as high as the rate for the young. The differences reflect larger numbers of aged persons in the nation, higher utilization of hospital care by the aged, and the fact that hospital costs soared 15 percent after price controls in the health care industry were removed in April 1974.

Personal health care expenditures per capita for the population as a whole climbed to $476 in fiscal year 1975 (Table 2). The average health bill for persons aged 65 or older was $1,360 or more than six times the average expenditure for those under age 19 ($212) and almost three times the average expense for those aged 19–64 ($472). Per capita expenses for the aged were 15 percent higher than they were in 1974.

As Table 1 indicates, the public sector has met the greatest portion—66 percent—of total personal health care expenditures of the aged. In 1966, before Medicare and Medicaid went into operation, public funds financed 30 percent of health care expenditures for the aged. And as Tables 3, 4, and 5 below demonstrate, the Medicare program, in particular, has afforded the aged invaluable protection against rapidly increasing health care expenditures. In fiscal year 1975, 21.6 million aged persons (over 95 percent of the elderly) had hospital insurance Part A protection and 21.5 million aged (over 94 percent of the aged population) were covered under the supplementary medical insurance Part B program. In addition, nearly one-fifth of the elderly receive Medicaid benefits that supplement Medicare protection or pay the premium costs for the supplementary medical insurance part of the program. Private payments, consisting of private health insurance premiums and direct payments to providers of services, constituted 34 percent of total health expenditures for the aged in 1975. (It should be noted that if supplementary medical insurance Part B payments were regarded as private payments by the elderly, the public share of the aged personal health care bill would be reduced from 66 to 61 percent.)

99-337—78——6

TABLE 1.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FOR 3 AGE GROUPS, FISCAL YEARS 1973–75[1]

[In millions]

Type of expenditure	All ages			Under 19			19 to 64			65 and over		
	Total	Private	Public	Total	Private	Public	Total	Private	Public	Total	Private	Public
1975 (Preliminary estimates)												
Total	$103,200	$62,276	$40,924	$15,406	$11,657	$3,749	$57,411	$40,153	$17,258	$30,383	$10,466	$19,917
Hospital care	46,600	20,957	25,643	5,173	3,063	2,110	27,960	16,515	11,445	13,467	1,379	12,088
Physicians' services	22,100	16,245	5,855	5,083	4,431	652	12,155	9,826	2,329	4,862	1,987	2,875
Dentists' services	7,500	7,085	415	1,545	1,387	158	5,415	5,196	219	540	502	38
Other professional services	2,100	1,591	509	462	378	84	1,197	993	204	441	220	221
Drugs and drug sundries	10,600	9,695	905	2,014	1,893	121	5,957	5,517	440	2,629	2,285	344
Eyeglasses and appliances	2,300	2,198	102	379	365	15	1,415	1,335	80	506	498	8
Nursing-home care	9,000	3,799	5,201	225	139	86	1,125	88	1,037	7,650	3,571	4,079
Other health services	3,000	707	2,293	525	1	524	2,187	682	1,505	288	24	264
1974 (Revised estimates)												
Total	90,088	56,630	33,458	13,761	10,438	3,323	50,581	36,096	14,485	25,746	10,096	15,651
Hospital care	39,963	18,639	21,324	4,476	2,572	1,904	24,258	14,491	9,767	11,230	1,577	9,653
Physicians' services	19,571	14,834	4,737	4,501	3,953	548	10,764	8,852	1,912	4,306	2,028	2,278
Dentists' services	6,783	6,450	333	1,458	1,334	125	4,863	4,686	177	461	430	31
Other professional services	1,927	1,576	351	424	359	65	1,098	949	149	405	268	136
Drugs and drug sundries	9,612	8,862	750	1,855	1,755	101	5,450	5,086	364	2,307	2,021	286
Eyeglasses and appliances	2,160	2,070	90	356	343	14	1,328	1,259	70	475	468	7
Nursing-home care	7,450	3,574	3,876	186	122	64	931	169	762	6,332	3,282	3,050
Other health services	2,622	625	1,997	503	1	503	1,888	604	1,284	231	20	210
1973 (Revised estimates)												
Total	82,490	52,428	30,062	13,011	9,507	3,504	46,360	33,927	12,433	23,119	8,994	14,126
Hospital care	36,155	17,113	19,042	4,086	2,234	1,852	22,091	13,663	8,427	9,979	1,216	8,763
Physicans' services	17,995	13,861	4,134	4,139	3,642	496	9,897	8,453	1,444	3,959	1,765	2,194
Dentists' services	6,101	5,780	321	1,318	1,203	115	4,405	4,229	176	378	347	31
Other professional services	1,781	1,440	341	392	317	75	997	854	143	392	269	123
Drugs and drug sundries	8,987	8,272	715	1,752	1,652	100	5,168	4,823	345	2,067	1,798	209
Eyeglasses and appliances	1,986	1,905	81	328	315	13	1,221	1,159	62	437	431	6
Nursing-home care	6,650	3,477	3,173	166	114	52	831	223	609	5,652	3,141	2,512
Other health services	2,835	579	2,256	831	29	802	1,749	522	1,227	255	28	227

[1] Marjorie Smith Mueller and Robert M. Gibson, "Age Differences in Health Care Spending, Fiscal Year 1975." Social Security Bulletin, June 1976.

TABLE 2.—ESTIMATED PER CAPITA PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FOR 3 AGE GROUPS, FISCAL YEARS 1973–75

Type of expenditure	All ages			Under 19			19 to 64			65 and over		
	Total	Private	Public	Total	Private	Public	Total	Private	Public	Total	Private	Public
1975 (Preliminary estimates)												
Total	$476.40	$287.48	$188.92	$212.14	$160.52	$51.62	$471.88	$330.03	$141.85	$1,300.16	$468.53	$891.63
Hospital care	215.12	96.74	118.38	71.23	42.17	29.05	229.82	135.74	94.07	602.89	61.75	541.14
Physicians' services	102.02	74.99	27.03	69.99	61.02	8.98	99.91	80.77	19.14	217.66	88.96	128.69
Dentists' services	34.62	32.71	1.92	21.27	19.10	2.17	44.51	42.71	1.80	24.17	22.45	1.72
Other professional services	9.69	7.35	2.35	6.36	5.21	1.15	9.84	8.17	1.67	19.74	9.83	9.91
Drugs and drug sundries	48.93	44.76	4.18	27.73	26.07	1.66	48.96	45.35	3.62	117.68	102.30	15.38
Eyeglasses and appliances	10.62	10.15	.47	5.23	5.03	.20	11.63	10.97	.65	22.65	22.29	.36
Nursing-home care	41.55	17.54	24.01	3.10	1.91	1.19	9.25	.73	8.52	342.57	159.88	182.58
Other health services	13.85	3.26	10.59	7.23	.01	7.22	17.98	5.61	12.37	12.89	1.05	11.84
1974 (Revised estimates)												
Total	419.44	263.66	155.78	187.70	142.38	45.32	422.64	301.61	121.03	1,181.46	463.27	718.20
Hospital care	186.06	86.78	99.28	61.05	35.08	25.97	202.09	121.08	81.61	515.31	72.35	442.95
Physicians' services	91.12	69.06	22.06	61.40	53.92	7.48	89.94	73.97	15.97	197.58	93.05	104.53
Dentists' services	31.58	30.03	1.55	19.89	18.19	1.70	40.64	39.16	1.48	21.17	19.75	1.42
Other professional services	8.97	7.34	1.63	5.78	4.90	.89	9.18	7.93	1.25	18.57	12.31	6.26
Drugs and drug sundries	44.75	41.26	3.49	25.30	23.93	1.37	45.54	42.50	3.04	105.88	93.76	13.10
Eyeglasses and appliances	10.06	9.64	.42	4.86	4.68	.18	11.10	10.52	.58	21.81	21.49	.31
Nursing-home care	34.69	16.64	18.05	2.54	1.67	.87	7.78	1.41	6.37	290.59	150.61	139.98
Other health services	12.21	2.91	9.30	6.87	.01	6.85	15.77	5.04	10.73	10.59	.94	9.05
1973 (Revised estimates)												
Total	386.84	245.86	140.98	175.66	128.35	47.31	393.58	288.03	105.55	1,081.35	420.66	660.69
Hospital care	160.55	80.25	89.30	55.16	30.16	25.00	187.54	116.00	71.55	466.73	56.87	409.87
Physicians' services	84.39	65.00	19.39	55.88	49.13	6.70	84.02	71.76	12.26	185.17	82.56	102.61
Dentists' services	28.61	27.10	1.51	17.79	16.25	1.55	37.40	35.90	1.49	17.69	16.23	1.46
Other professional services	8.35	6.75	1.60	5.29	4.28	1.01	8.47	7.25	1.21	18.33	12.57	5.76
Drugs and drug sundries	42.15	38.79	3.35	23.66	22.30	1.36	43.87	40.94	2.93	96.68	84.08	12.59
Eyeglasses and appliances	9.31	8.93	.38	4.42	4.25	.17	10.37	9.84	.53	20.44	20.15	.28
Nursing-home care	31.19	16.31	14.88	2.24	1.54	.70	7.06	1.89	5.17	264.38	146.89	117.49
Other health services	18.30	2.72	10.58	11.21	.39	10.83	14.85	4.44	10.41	11.93	1.31	10.62

TABLE 3.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES UNDER PUBLIC PROGRAMS, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FOR 3 AGE GROUPS, FISCAL YEARS 1973–75

[In millions]

Type of expenditure	All ages			Under 19			19 to 64			65 and over		
	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local
1975 (Preliminary estimates)												
Total	$40,924	$28,578	$12,346	$3,749	$2,391	$1,358	$17,258	$9,856	$7,402	$19,917	$16,331	$3,586
Hospital care	25,643	18,263	7,380	2,110	1,373	737	11,445	6,298	5,147	12,088	10,592	1,496
Physicians' services	5,855	4,262	1,593	652	391	260	2,329	1,116	1,213	2,875	2,755	119
Dentists' services	415	255	160	158	88	70	219	141	78	38	26	13
Other professional services	509	342	167	84	52	31	204	94	109	221	196	26
Drugs and drug sundries	905	478	427	121	68	52	440	225	215	344	184	159
Eyeglasses and appliances	102	57	45	15	10	5	80	40	39	8	7	1
Nursing-home care	5,201	2,982	2,219	86	46	40	1,037	588	448	4,079	2,347	1,731
Other health services	2,293	1,939	354	524	362	162	1,505	1,354	151	264	223	41
1974 (Revised estimates)												
Total	33,458	22,959	10,499	3,323	2,187	1,135	14,485	8,022	6,463	15,651	12,750	2,901
Hospital care	21,324	14,626	6,698	1,904	1,275	629	9,767	5,102	4,665	9,653	8,249	1,404
Physicians' services	4,737	3,420	1,318	548	339	209	1,912	899	1,013	2,278	2,181	97
Dentists' services	333	215	117	125	73	51	177	120	57	31	22	9
Other professional services	351	224	126	65	41	21	149	65	84	136	119	18
Drugs and drug sundries	750	410	340	101	59	42	364	191	173	286	160	126
Eyeglasses and appliances	90	50	40	14	9	5	70	35	34	7	6	1
Nursing-home care	3,876	2,314	1,562	64	36	28	762	447	315	3,050	1,832	1,218
Other health services	1,997	1,699	298	503	355	148	1,284	1,162	122	210	182	29
1973 (Revised estimates)												
Total	30,062	20,178	9,884	3,504	2,139	1,366	12,433	6,516	5,916	14,126	11,524	2,602
Hospital care	19,042	12,793	6,249	1,852	1,241	611	8,427	4,095	4,333	8,763	7,457	1,306
Physicians' services	4,134	3,008	1,126	496	319	177	1,444	577	867	2,194	2,112	82
Dentists' services	321	218	104	115	69	45	176	125	50	31	23	8
Other professional services	341	224	117	75	52	23	143	66	77	123	106	17
Drugs and drug sundries	715	387	328	100	60	41	345	180	165	269	147	122
Eyeglasses and appliances	81	45	35	13	8	4	62	32	30	6	5	1
Nursing-home care	3,173	1,849	1,323	52	28	24	609	341	267	2,512	1,480	1,032
Other health services	2,256	1,654	601	802	361	441	1,227	1,100	127	227	194	34

TABLE 4.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES UNDER PUBLIC PROGRAMS, BY PROGRAM AND SOURCE OF FUNDS, FOR 3 AGE GROUPS, FISCAL YEARS 1973-75

[In millions]

Program	All ages			Under 19			19 to 64			65 and over		
	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local
1975 (Preliminary estimates)												
Total	$40,924	$28,578	$12,346	$3,749	$2,391	$1,358	$17,258	$9,856	$7,402	$19,917	$16,331	$3,586
Health insurance for the aged and disabled	14,121	14,121		3	3		1,355	1,355		12,762	12,762	
Temporary disability insurance	73		73				73		73			
Workmen's compensation (medical benefits)	1,830	51	1,779				1,773	49	1,724	57	2	55
Public assistance (vendor medical payments)	12,487	6,692	5,795	2,098	1,125	974	5,475	2,934	2,541	4,914	2,633	2,280
General hospital and medical care	5,492	1,090	4,402	518	320	198	3,638	685	2,954	1,335	85	1,250
Defense Department hospital and medical care (including military dependents)	2,989	2,989		726	726		2,173	2,173		90	90	
Maternal and child health services	535	272	263	365	186	179	171	87	84			
School health												
Veterans' hospital and medical care	3,206	3,026					2,450	2,450		756	756	
Medical vocational rehabilitation	190	157	33	38	31	7	148	122	26	4	3	1
Office of Economic Opportunity												
1974 (Revised estimates)												
Total	33,458	22,959	10,499	3,323	2,187	1,135	14,485	8,022	6,463	15,651	12,750	2,901
Health insurance for the aged and disabled	10,680	10,680		2	2		798	798		9,879	9,879	
Temporary disability insurance	71		71				71		71			
Workmen's compensation (medical benefits)	1,560	36	1,524				1,510	35	1,475	50	1	49
Public assistance (vendor medical payments)	9,938	5,563	4,375	1,732	969	762	4,465	2,499	1,965	3,742	2,095	1,647
General hospital and medical care	5,061	821	4,240	452	261	191	3,357	512	2,845	1,252	48	1,204
Defense Department hospital and medical care (including military dependents)	2,719	2,719		767	767		1,881	1,881		71	71	
Maternal and child health services	489	230	259	333	157	176	156	73	83			
School health												
Veterans' hospital and medical care	2,756	2,756					2,103	2,103		653	653	
Medical vocational rehabilitation	185	154	31	37	31	6	144	120	24	4	3	1
Office of Economic Opportunity												

TABLE 4.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES UNDER PUBLIC PROGRAMS, BY PROGRAM AND SOURCE OF FUNDS, FOR 3 AGE GROUPS, FISCAL YEARS 1973–75—Con.

[In millions]

Program	All ages			Under 19			19 to 64			65 and over		
	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local	Total	Federal	State and local
1973 (Revised estimates)												
Total	30,062	20,178	9,884	3,504	2,139	1,366	12,433	6,516	5,916	14,126	11,524	2,602
Health insurance for the aged	9,040	9,040								9,040	9,040	
Temporary disability insurance	70		70				70		70			
Workmen's compensation (medical benefits)	1,335	32	1,303				1,292	31	1,261	43	1	42
Public assistance (vendor medical payments)	8,817	4,783	4,034	1,581	858	723	4,068	2,207	1,861	3,168	1,719	1,450
General hospital and medical care	4,712	805	3,908	441	265	176	3,095	473	2,622	1,177	67	1,110
Defense Department hospital and medical care (including military dependents)	2,448	2,448		774	774		1,606	1,606		69	69	
Maternal and child health services	451	216	234	307	147	160	144	69	75			
School health	300		300	300		300						
Veterans' hospital and medical care	2,561	2,561					1,955	1,955		606	606	
Medical vocational rehabilitation	175	140	35	35	28	7	136	109	27	3	3	1
Office of Economic Opportunity	152	152		67	67		66	66		20	20	

B. Experience under medicare

As noted above, the government's role in financing health care expenditures for the aged has increased substantially—from 30 percent in 1966 to 66 percent in 1975. However, from 1969 to 1975 the Medicare share of the aged's total health bill and its hospital and physicians' care components has decreased. This can be explained by a number of factors. The average length of hospital stay for the older group has been declining by more than three percent a year during much of the period 1969–74. As a result, the patient's initial share of the hospital bill—a deductible roughly equivalent to the average cost nationally of a day of care—has become a larger proportion of the total bill and the Medicare proportion has become smaller. In 1976, this deductible stood at $104 and in 1977 it increased to $124.

In addition, expenditures have been increasing for outpatient hospital diagnostic and therapeutic services, which are reimbursed from the Medicare supplementary medical insurance trust fund. These expenses are reimbursed at a lower rate than those for inpatient hospital care because of the 20 percent coinsurance requirement.

The decline in Medicare's share of expenditures for physicians' services has resulted partly from the increase in the deductible for the Part B program from $50 to $60 in 1973, but an even more important factor has been the increasing proportion of claims for which physicians will not accept assignment. Physicians who do not accept assignment may bill the patient for more than Medicare's "reasonable charges." In fiscal year 1969, the net assignment rate (excluding hospital-based physicians) was 61 percent. In 1974, it had declined to 52 percent and by fiscal year 1976 had declined further to 51 percent. As a result, a greater proportion of total charges is being met through private insurance, Medicaid, or out-of-pocket payments by the patient and a smaller proportion by Medicare.

Although still not at the 1969 level, Medicare's share of the elderly's health bill in 1975 showed a sizeable increase over the 1974 level, reaching 42 percent of the total (see Table 5). For hospital care, Medicare's share rose to 72 percent in contrast to the previous high of 66 percent in 1969. For physicians' and other professional services, the 1975 shares were 54 percent and 38 percent, respectively; these compare with a high of 60 percent for physicians' services in 1969 and a previous high of 31 percent for other professional services in 1970.

During the past several years, only about three percent of nursing home expenditures have been paid by Medicare. By contrast, in 1968, toward the beginning of the program and before controls on the use of skilled-nursing facilities were tightened, Medicare covered nearly 16 percent of total outlays for care of the aged in nursing homes. Since the program does not pay for dental care, out-of-hospital prescribed drugs, or eyeglasses, Medicare's share in the financing of total health care for the aged has not kept pace with the advance of its share of financing hospital and medical services.

TABLE 5.—ESTIMATED AMOUNT AND PERCENTAGE DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES FOR THE AGED, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FISCAL YEARS 1973–75

Type of expenditure	Amount (in millions)					Percentage distribution				
			Public					Public		
	Total	Private	Total	Medicare	Other	Total	Private	Total	Medicare	Other
1975 (Preliminary estimates)										
Total	$30,383	$10,466	$19,917	$12,762	$7,155	100.0	34.4	65.6	42.0	23.5
Hospital care	13,467	1,379	12,088	9,725	2,363	100.0	10.2	89.8	72.2	17.5
Physicans' services	4,852	1,987	2,875	2,629	246	100.0	40.9	59.1	54.1	5.1
Dentists' services	540	502	38	----------	38	100.0	92.9	7.1	----------	7.1
Other professional services	441	220	221	167	54	100.0	49.8	50.2	38.0	12.2
Drugs and drug sundries	2,629	2,285	344	----------	344	100 0	86.9	13.1	----------	13.1
Eyeglasses and appliances	506	498	8	----------	8	100.0	93.4	1.6	----------	1.6
Nursing-home care	7,650	3,571	4,079	241	3,838	100.0	46.7	53.3	3.1	50.2
Other health services	288	24	264	----------	264	100.0	8.2	91.8	----------	91.8
1974 (Revised estimates)										
Total	25,746	10,096	15,651	9,878	5,773	100.0	30.2	60.8	38.4	22.4
Hospital care	11,230	1,577	9,653	7,517	2,136	100.0	14.0	86.0	66.9	19.0
Physicians' services	4,306	2,028	2,278	2,072	205	100.0	47.1	52.9	48.1	4.8
Dentists' services	461	430	31	----------	31	100.0	93.3	6.7	----------	6.7
Other professional services	405	268	136	98	38	100.0	66.3	33.7	24.2	9.5
Drugs and drug sundries	2,307	2,021	286	----------	286	100.0	87.6	12.4	----------	12.4
Eyeglasses and appliances	475	468	7	----------	7	100.0	98.6	1.4	----------	1.4
Nursing-home care	6,332	3,282	3,050	190	2,860	100.0	51.8	48.2	3.0	45.2
Other health services	231	20	210	----------	210	100.0	8.8	91.2	----------	91.2
1973 (Revised estimates)										
Total	23,119	8,994	14,126	9,040	5,085	100.0	38.9	61.1	39.1	22.0
Hospital care	9,979	1,216	8,763	6,768	1,995	100.0	12.2	87.8	67.8	20.0
Physicians' services	3,959	1,765	2,194	2,016	178	100.0	44.6	55.4	50.9	4.5
Dentists' services	378	347	31	----------	31	100.0	91.7	8.3	----------	8.3
Other professional services	392	269	123	83	40	100.0	68.6	31.4	21.2	10.3
Drugs and drug sundries	2,067	1,798	269	----------	269	100.0	87.0	13.0	----------	13.0
Eyeglasses and appliances	437	431	6	----------	6	100.0	98.6	1.4	----------	1.4
Nursing-home care	5,652	3,141	2,512	173	2,339	100.0	55.6	44.4	3.1	41.4
Other health services	255	28	227	----------	227	100.0	11.0	89.0	----------	89.0

C. Private health insurance coverage and out-of-pocket expenditures for the aged

The role of private health insurance with respect to expenditures for the aged diminished rapidly with the advent of the Medicare program. Although the number of aged persons who carry private insurance is now even larger than it was before Medicare, insurance payments now make up only about five percent of their total outlays compared with about 16 percent in 1966 (Table 6). Private insurance for the elderly primarily supplements or complements the Medicare benefit structure and generally covers some portion of the deductibles and coinsurance required under the program. However, only a relatively small proportion of the aged have private health insurance for services not covered by Medicare. such as prescribed drugs. The following tabulation gives the percentage of the aged population with private insurance, as of December 31, 1974.

Type of coverage:	*Percent of aged population*
Hospital care	57.9
Physicians' services:	
Surgical services	54.0
Inhospital visits	40.3
X-ray and laboratory examinations	31.7
Office and home visits	35.5
Dental care	1.9
Prescription drugs	16.9
Private-duty nursing	16.8
Visiting-nursing services	21.0
Nursing home care	15.8

TABLE 6.—AMOUNT AND PERCENT OF EXPENDITURES FOR PERSONAL HEALTH CARE MET BY 3D PARTIES FOR THE AGED 65 AND OVER, FISCAL YEARS 1966–77

Fiscal year	Total	Direct payments	3d-party payments			
			Total	Private health insurance	Government	Philanthropy and industry
AGED 65 AND OVER						
Total amount (in millions):						
1966	$8,242	$4,382	$3,860	$1,309	$2,460	$91
1967	10,041	3,716	6,325	589	5,660	76
1968	12,362	3,401	8,961	658	8,229	74
1969	14,342	4,019	10,323	769	9,476	78
1970	16,514	5,387	11,127	908	10,138	81
1971	19,015	6,505	12,510	1,020	11,400	90
1972	21,649	7,696	13,953	1,117	12,742	94
1973 [1]	23,119	7,636	15,483	1,257	14,126	100
1974 [1]	25,746	8,540	17,206	1,446	15,651	109
1975 [2]	30,383	8,709	21,674	1,640	19,917	116
Per capita amount:						
1966	$445.25	$236.72	$208.52	$70.71	$132.89	$4.92
1967	535.03	193.01	337.03	31.38	301.59	4.05
1968	646.65	177.90	468.75	34.42	430.45	3.87
1969	735.19	206.02	529.17	39.42	485.75	4.00
1970	828.31	270.20	558.11	45.54	508.50	4.06
1971	925.98	316.78	609.20	49.67	555.15	4.38
1972	1,033.51	367.40	666.11	53.33	608.30	4.49
1973 [1]	1,081.35	357.16	724.19	58.81	660.69	4.70
1974 [1]	1,181.46	391.90	789.56	66.35	718.20	5.01
1975 [2]	1,360.16	389.88	970.28	73.44	891.63	5.22
			Figures in percent			
Percentage distribution:						
1966	100.0	53.2	46.8	15.9	29.8	1.1
1967	100.0	37.0	63.0	5.9	56.4	.8
1968	100.0	27.5	72.5	5.3	66.6	.6
1969	100.0	28.0	72.0	5.4	66.1	.5
1970	100.0	32.6	67.4	5.5	61.4	.5
1971	100.0	34.2	65.8	5.4	60.0	.5
1972	100.0	35.6	64.5	5.2	58.9	.4
1973 [1]	100.0	33.0	67.0	5.4	61.1	.4
1974 [1]	100.0	33.2	66.8	5.6	60.8	.4
1975 [2]	100.0	28.7	71.3	5.4	65.6	.4

[1] Revised estimates.
[2] Preliminary estimates.

Despite third-party payments by government programs and private health insurance coverage, 29 percent of the nation's health bill for the aged was paid directly from their own resources in 1975 (Table 6). Direct expenditures generally paid for services covered neither by Medicare nor private insurance. (Not included in the direct payments are private insurance premiums and the premiums for supplementary medical insurance Part B program also paid by the aged, or in some cases by employers in their behalf.) In 1975, out-of-pocket payments by the elderly for their health care on a per capita basis amounted to $389.88. This amount is greater than per capita out-of-pocket payments by the elderly in 1966, prior to coverage by the Medicare program, and about twice as great as out-of-pocket payments required by beneficiaries during each of the first two years of the program's operation. As health care costs increase, services, which at one time might have been considered budgetable expenses, become a financial burden and drain on a relatively fixed income.

D. Experience of the aged with medicaid

As a result of the enactment of the Medicaid program, needy aged persons who meet income and resource requirements of the program have been provided accessibility to health care services which would not otherwise be available to them because of gaps in coverage under the Medicare program or private health insurance policies. In fiscal year 1973, there were 3,549,000 aged Medicaid recipients; these persons constituted 19.2 percent of total Medicaid recipients. On behalf of these elderly recipients, there was spent in 1973 $3.2 billion, or 39.5 percent of total program expenditures.

The expenditures for the aged under Medicaid are related to coverage of various services under Medicare. As Tables 7 and 8 indicate, relatively small proportions of program expenditures are made for inpatient hospital care and

physicians' services for the aged, reflecting the coverage of those services under Medicare, while the larger percentages for nursing home care, intermediate care, prescribed drugs, reflect the limitation on coverage, or lack of coverage, of those services under the Medicare program.

TABLE 7.—THE MEDICAID DOLLAR IS SPENT DIFFERENTLY IN EACH ELIGIBILITY CATEGORY (BY PERCENTAGE SHARE)

Title XIX services	Basis of eligibility					
	All recipients	Aged	Blind	Disabled	Children under 21	Adults in AFDC families
Total	100.0	100.0	100.0	100.0	100.0	100.0
Inpatient hospital care	28.4	5.1	25.8	38.8	42.1	48.7
Nursing home care	22.1	45.8	26.6	16.6	2.2	.5
Intermediate care	13.7	25.8	13.4	14.1	1.8	.1
Physicians' services	13.2	4.8	10.8	10.3	24.2	23.5
Dental care	2.5	.6	1.1	1.2	6.3	4.6
Prescribed drugs	8.7	10.0	11.9	7.7	6.4	9.6
Other services	11.4	8.0	10.4	11.3	17.0	13.0

Source: B–4 reports, fiscal year 1973 (unpublished data). Colorado, Massachusetts, New York, Rhode Island, and Guam did not report data and are not included.

TABLE 8.—THE ELIGIBILITY CATEGORIES ACCOUNT FOR VARYING PERCENTAGES OF THE TOTAL SPENT ON EACH OF THE MAJOR MEDICAID SERVICES (BY PERCENTAGE SHARE)

Basis of eligibility	Title XIX services							
	Total	Inpatient hospital care	Nursing home care	Intermediate care facilities services	Physicians' services	Dental care	Prescribed drugs	Other services
All recipients	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Aged	37.8	6.9	78.2	71.2	13.7	8.5	43.1	26.7
Blind	1.0	.9	1.2	1.0	.8	.4	1.4	.9
Disabled	24.7	33.7	18.5	25.5	19.3	11.6	21.8	24.6
Children under 21	17.1	25.2	1.7	2.2	31.5	43.8	12.5	25.5
Adults in AFDC families	19.4	33.3	.4	.1	34.7	35.7	21.2	22.3

Source: NCSS B–4, report, fiscal year 1973 (unpublished data). Colorado, Massachusetts, New York, Rhode Island, and Guam did not report data and are not included.

Despite these accomplishments, the scope of care and services made available under the plan has not become as comprehensive as originally anticipated. Section 1903(e) of the Medicaid statute specified at the time of enactment that:

"The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

As the result of an amendment adopted by the Congress in 1969 (P.L. 91–36), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive Medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977. And in 1972, Congress repealed this requirement with the enactment of the Social Security Amendments of 1972. The Senate Finance Committee noted in its report on this legislation (No. 92–1230):

"The committee has been concerned with the burden of the medicaid program on State finances. The expansion of the medicaid program and liberalization of eligibility requirements for medical assistance which is required by section

1903(e) could increase this burden and may result in States either cutting back on other programs or their considering dropping medicaid.

"The committee agrees with the action of the House repealing section 1903(e). When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in other medical costs inflation, the question of expansion of the program can then be reconsidered."

This change in emphasis on the Federal level has been accompanied by cutbacks in benefits at the State level. States are permitted to alter their Medicaid program at any time with Federal approval as long as the program remains within Federal guidelines. Such alterations reflect shifting policy considerations, such as the desire to gradually expand or gradually limit the State program, or can be made as a result of temporary budgetary problems within the State. Since the enactment of Medicaid, fiscal problems in many States have led to a number of cutbacks in State programs. Table 9 below indicates typical reductions in benefits offered by State Medicaid programs. It should be noted that the cutbacks listed below were instituted during the period January 1 through October 1, 1975 alone, and often involve those health care services, e.g., dental services, vision care services, prescription drugs, for which the elderly have a special need and which the Medicare program does not offer insurance protection. The result is even higher out-of-pocket expenditures for the aged.

TABLE 9.—*Cutbacks in State Medicaid Programs—January 1 through October 1, 1975*

Alabama

a. Reduced inpatient hospital days from 30 to 20 per year.

b. Limited physicians' visits for chronic stable illnesses outside hospital to one visit per month.

c. Limited physicians' visits for hospital confined patients to one visit per day.

d. Imposed 50 cents copayment per prescription refill per patient.

e. No longer allow bed reservations up to seven days in nursing home while patient is in hospital.

f. Placed State reimbursement ceiling of $21.50 per day for SNF's and $19.35 per day for ICFs.

g. Reduced personal needs allowance for aged, blind, and disabled nursing home recipients from $45 average per month to $25 per month.

Alaska

Removed the category of unborn children from coverage on Title IV–A (AFDC) financial assistance and thus terminated Medicaid coverage for this group.

Florida

On January 1, 1975, Florida eliminated prosthetic devices from the State Plan. This included dentures, eyeglasses, hearing aids, and artificial limbs. Also eliminated were optometrists' services, other practitioners' services, and dental services. During the second quarter of calendar year 1975, a limitation was placed on drugs of $20 per month per recipient.

Georgia

a. Adult dental services and dentures deleted.

b. Adult optical services deleted.

c. Physicians' home office visits are limited to one visit per month unless a medically justifiable need for exceptions exists.

d. Outpatient hospital visits are limited to one visit per month unless a medically justifiable need for exceptions exists.

e. Inpatient hospital visits are limited to one visit per day unless a medically justifiable need for exceptions exists.

f. Nursing home visits are limited to one visit per month unless a medically justifiable need for exceptions exists.

g. Imposed 50 cents copayment per prescription/refill.

h. Imposed copayments on (1) ambulance services, (2) durable medical equipment, (3) orthotic/prosthetic services.

i. Reduced personal needs allowance for aged, blind, and disabled recipients from $25 (plus up to $20 non-covered medical expenses) to $25 per month with no allowance for non-covered medical expenses.

j. Prior approval for many physicians' services and related hospital admissions.

Illinois

a. Change in reimbursement rate for drugs from cost plus percent of cost, to cost plus a dispensary fee. Implemented a physician authorization supplemental to a prescription for over-the-counter drugs.

b. Skilled nursing facility and intermediate care facility reimbursement rates were frozen in March 1975.

Louisiana

The following reductions were made: (a) unlimited coverage of physicians' services was limited to coverage of 12 visits per year with extensions beyond this limit subject to prior approval; (b) additional allowances for injections were eliminated except for injections related to a program of therapy, and (c) elimination of non-legend drugs except for insulin, calcium, iron, nicotinic acid. Temporary suspension of dental program, which was restructured and reinstated on November 1, 1975.

Maine

a. Deleted day treatment form mental health clinic services as of April 1, 1975.

b. Deleted unborn children coverage group effective as of April 1, 1975.

c. Deleted in-hospital private rooms and private duty nursing effective as of July 1, 1975.

Maryland

a. Dental care for adults over 21 has been deleted except for emergency.

b. Ban of State payment for certain items, i.e., needles and syringes, insulin, and family planning products except for nursing home patients who will continue to be covered.

c. Fifty cents copayment on all drugs covered, except for nursing home patients.

d. One pair of eyeglasses and one eye examination for adults, limited to every two years. One pair of eyeglasses and one eye examination for children limited to once a year. No replacement for broken or lost glasses for either adults or children.

e. Eliminating payment for hospital inpatient "medical-social" days.

f. Eliminating routine foot care for all persons except those who are diabetic or have vascular diseases.

g. Eliminating custom foot supplies.

h. Disposable supplies eliminated with exception of ostomy supplies.

i. All durable convenience supplies eliminated.

j. A number of administrative control changes, i.e., limitation of prior approvals.

Nevada

Deleted intermediate care facility services for individuals age 65 or older in institutions for tuberculosis.

New Hampshire

Deleted dental care for adult programs effective as of July 1, 1975. The State still provides dental care for children under 21 (EPSDT) and emergency treatment for adults to relieve pain.

New Jersey

a. A program of copayments for prescription drugs was begun which required Medicaid recipients to pay 25 cents for each prescription.

b. Non-legend drugs are no longer reimbursed except for insulin and contraceptives.

c. Dispensing fees for pharmacies were reduced by 25 cents.

d. Reimbursement for physicians, dentists, optometrists, opticians, podiatrists, chiropractors, psychologists, prosthetic and orthotic suppliers, medical suppliers, hearing aid dealers, and transportation.

e. Reimbursement for laboratory services performed by physicians and independent laboratories was reduced by 40 percent.

f. As of September 1, 1975, replacement of lost or broken eyeglasses are no longer reimbursed, except under extraordinary circumstances and with prior authorization. The period before which dentures can be replaced under Medicaid reimbursement has been extended from three years to five years and requirements for obtaining orthodontic care is more restrictive.

South Dakota

Restricted the drugs available under its program to effect a 40 percent reduction in expenditures.

Texas

Coverage of psychiatric care for persons age 65 and older in mental hospitals was terminated, effective September 1, 1975.

Virginia

a. Inpatient hospital coverage limited to 14 days. Coverage may be extended up to 21 days for certain admissions based on medical necessity. (Effective January 15, 1975).

b. Eliminated most non-legend (OTC) drug items effective January 15, 1975. Therefore, the Program will not provide reimbursement for drugs having an "8" as the first digit of the drug code, except for certain specified insulin syringes, needles, and family planning supplies. Imposed a 50 cents co-payment on each prescription and refill dispensed.

c. Legend drugs therapeutically classified as anorexants no longer covered after January 14, 1975.

d. Propoxyphene drugs not covered after January 14, 1975.

e. There is a $2 charge to the patient for each pair of eyeglasses.

f. There is a $2 charge to the patient on the repair or replacement of parts of eyeglasses costing $5 or more.

g. Eliminated the $1.50 growth and development factor from nursing home payments.

Wisconsin

a. Reimbursement rates for all services are frozen at December 23, 1974 level.

b. The personal needs allowance for the institutionalized individual has been reduced from $45 to a minimum of $25.

III. OPTIONS FOR IMPROVING PROTECTION UNDER MEDICARE AND MEDICAID

A. *Medicare*

1. *Freeze or otherwise moderate increases in deductibles, coinsurance rates, and premiums required under the program.*—Table 10 below details increases in deductibles and coinsurance amounts in the hospital insurance Part A program since 1966. Table 11 indicates changes in the monthly premium for the supplementary medical insurance Part B plan since enactment. In addition, it should be noted that the annual deductible for the Part B plan increased in 1973 to $60.

TABLE 10.—MEDICARE COST-SHARING: HOSPITAL INSURANCE DEDUCTIBLE COINSURANCE AMOUNTS, 1966–77

Effective date	Inpatient hospital deductible	Coinsurance amount per day for—		
		Hospitals, 61st to 90th day [1]	Hospitals, 60 lifetime reserve days [2]	SNF's 21st to 100th day [3]
July 1966	$40	$10	$20	$5.00
January:				
1967	40	10	20	5.00
1968	40	10	20	5.00
1969	44	11	22	5.50
1970	52	13	26	6.50
1971	60	15	30	7.50
1972	68	17	34	8.50
1973	72	18	36	9.00
1974	84	21	42	10.50
1975	92	23	46	11.50
1976	104	26	52	13.00
1977	124	31	62	15.50

[1] ¼ of the deductible.
[2] ½ of the deductible.
[3] ⅛ of the deductible.

TABLE 11.—*Increases in supplementary medical insurance monthly premiums*

Effective date:	*Premium*
July 1966	$3.00
April 1968	4.00
July 1970	5.30
July 1971	5.60
July 1972	5.80
August 1973	6.10
September 1973	6.30
July 1974	6.70
July 1975	6.70
July 1976	7.20

In December 1965, the average cash benefit under the Social Security program was approximately $84, and by the end of 1976 this benefit had increased to $225. When this cash benefit increase of 167 percent is compared to a 210 percent increase in the Part A inpatient hospital deductible and a 140 percent increase in premium charges for Part B coverage, it will be seen that the protection provided by the Medicare program, while still invaluable, has become an increasing financial burden for the elderly.

2. *Eliminate gaps in services and benefits covered by the program.*—As indicated above in the discussion on increasing out-of-pocket payments by the aged for health care services, neither the Medicare program nor private health insurance policies provide adequate protection against costs associated with dental care, prescription drugs, vision care, and nursing home care. These services could be covered under the Part B supplementary medical insurance program. The cost-sharing provisions of Part B would limit the program's liability and make beneficiaries cost-conscious and restrain unnecessary utilization.

3. *Eliminate benefit and service limitations so as to provide protection against expenses associated with catastrophic illness.*—It is recognized that Parts A and B currently provide important protection against the health care costs of the elderly. However, in those cases where extended periods of illness occur, service limitations and cost-sharing requirements of the program can result in impoverishing out-of-pocket payments by the aged. For the aged whose incomes are relatively fixed and whose resources are severely limited, catastrophic health insurance protection is needed; the Medicare program could be redesigned to provide this kind of protection.

B. Medicaid

If amendments to the Medicare program eliminate the gaps in services and benefits mentioned above, the Medicaid program could be amended to make health care services more accessible to the needy aged in the following ways:

1. *Eliminate resource requirements for program eligibility.*—For purposes of program eligibility, States currently impose various resource requirements, such as the maximum amount of real property and personal property which may be held by the individual to qualify for medical assistance under Medicaid. These resource requirements are independent of a regular monthly income available to the individual.

2. *Equalize income levels for medically needy programs and amend the "spend-down" provision of the program to require less than dollar-for-dollar spending to qualify for medically needy programs.*—Table 12 indicates the varying income levels established by States with medically needy programs. Persons and families meeting all other requirements for Medicaid eligibility, including resource levels, can become eligible for medical assistance if their income falls below these levels, even though they are not receiving a cash assistance payment. For persons and families with incomes higher than these levels, any medical expenses incurred can be deducted on a dollar-for-dollar basis from income in determining eligibility, allowing these persons to "spend-down" to Medicaid eligibility.

TABLE 12.—INCOME LEVELS FOR MEDICALLY NEEDY IN TITLE XIX PLANS IN OPERATION AS OF DECEMBER 1974—ANNUAL INCOME[1]

State	Income protected for maintenance, by number of persons in family				Plus dollars for additional persons
	1	2	3	4	
Arkansas (effective Jan. 1, 1975).	2,000	2,000	2,200	2,400	5—$2,700; 6—$2,800; 7—$3,000; 8—$3,100; 9—$3,200; $100 each additional person.
California	2,400	3,400	4,200	5,100	5—$5,700; 6—$6,400; 7—$7,200; 8—$7,800; 9—$8,400; 10 or more—$9,000.
Connecticut	2,300	2,900	3,400	4,000	5—$4,600; 6—$5,300; 7—$6,000; 8—$6,600; 9—$7,100; 10—$7,700.
District of Columbia	2,100	2,800	3,200	3,600	5—$4,000; 6—$4,400; 7—$4,800; 8—$5,200; 9—$5,600; 10—$6,000; $420 each additional person.
Guam	1,500	2,500	2,800	3,000	5—$3,200; 6—$3,400; 7—$3,600; 8—$3,800; 9—$4,000; 10—$4,200; $200 each additional person.
Hawaii	2,500	3,500	3,800	4,500	5—$5,000; 6—$5,500; 7—$6,200; 8—$6,700; 9—$7,100; 10—$7,700; $540 each additional person.
Illinois	1,800	2,400	3,000	3,600	5—$4,200; 6—$4,800; 7—$5,400; 8—$6,000; 9—$6,600; 10—$7,200; $600 each additional person.
Kansas	3,400	4,000	4,500	5,000	5—$5,400; 6—$5,900; 7—$6,300; 8—$6,600; 9—$7,000; 10—$7,400; $360 each additional person.
Kentucky	1,800	2,200	3,000	3,800	5—$4,400; 6—$5,000; 7—$5,600; 8—$6,200; 9—$6,800; 10—$7,400; $600 each additional person.
Maine	2,000	2,100	2,900	3,600	5—$4,200; 6—$4,900; 7—$5,600; 8—$6,300; 9—$7,000; 10—$7,700; $696 each additional person.
Maryland:					
Standard I[2]	1,700	2,300	2,700	3,200	5—$3,800; 6—$4,100; 7—$4,600; 8—$5,100; 9—$5,500; 10—$5,900; $600 each additional person.
Standard II[3]	1,800	2,300	2,700	3,200	For more than 4 persons, see standard I.
Massachusetts	3,000	4,100	4,700	5,300	5—$5,900; 6—$6,500; 7—$7,100; 8—$7,700; 9—$8,300; 10—$8,900; $600 each additional person.
Michigan[4]	2,600	3,400	4,200	4,900	5—$5,700; 6—$6,500; 7—$7,200; $732 each additional person.
Minnesota	2,600	3,300	3,900	4,500	5—$5,200; 6—$5,000; 7—$6,400; 8—$7,000; 9—$7,700; 10—$8,300; $624 each additional person.
Montana:					
Child(ren) Only	700	1,400	2,100	2,700	5—$3,400.
1 adult and child(ren)	2,100	2,700	3,600	4,100	5—$4,600.
2 adults and child(ren).		3,500	4,000	5,000	5—$5,600.
Nebraska	1,900	2,800	3,200	3,600	5—$4,000; 6—$4,400; 7—$4,800; 8—$5,200; 9—$5,600; 10—$6,000; $400 each additional person.
New Hampshire	3,000	3,500	4,100	4,600	5—$5,100; 6—$5,800; 7—$6,300; 8—$7,100; 9—$7,500; 10—$8,100; 11—$8,800; 12—$9,400; $564 each additional person.
New York	2,500	3,400	4,000	5,000	5—$5,700; 6—$6,400; 7—$7,200; 8—$7,800; 9—$8,400; 10—$9,000; $600 each additional person.
North Carolina	1,700	2,200	2,500	2,800	5—$3,000; 6—$3,200; 7—$3,400; 8—$3,600; 9—$3,800; 10—$4,000; $200 each additional person.
North Dakota	1,800	2,400	3,000	3,600	5—$4,100; 6—$4,600; 7—$5,100; $400 each additional person.
Oklahoma	1,600	2,400	3,000	3,700	5—$4,200; 6—$4,800; 7—$5,200; 8—$5,600; 9 or more—$6,000.
Pennsylvania	2,000	2,500	3,300	4,000	$750 each additional person.
Puerto Rico	2,500	3,200	3,800	4,400	5—$5,000; 6—$5,600; 7—$6,200; 8—$6,800; 9—$7,400; 10—$8,000; $600 each additional person.
Rhode Island	3,000	4,000	4,400	4,800	5—$5,200; 6—$5,600; 7—$6,000; 8—$6,400; 9—$6,800; 10—$7,200; $400 each additional person.
Tennessee	1,400	1,600	1,900	2,200	5—$2,400; 6—$2,700; 7—$2,900; 8—$3,200; 9—$3,500; 10—$3,900; $264 each additional person.
Utah	1,600	2,200	2,900	3,400	5—$4,400; 6—$5,100; 7—$5,500; 8—$5,800; 9—$6,200; 10—$6,600; $360 each additional person.
Blind	1,800	3,500	5,200	6,900	5—$8,600; 6—$10,300; 7—$12,100; 8—$13,800; $516 each additional person.
Vermont—Urban (Chittenden County)	2,700	3,400	3,900	4,400	5—$4,900; 6—$5,400; 7—$5,900; 8—$6,500; 9—$7,000; 10—$7,600; $540 each additional person.
All other areas	2,500	3,200	3,600	4,200	5—$4,700; 6—$5,100; 7—$5,700; 8—$6,300; 9—$6,800; 10—$7,400; $540 each additional person.
Virgin Islands	2,200	2,800	3,200	3,700	5—$4,100; 6—$4,400; 7—$5,000; 8—$5,400; 9—$5,900; 10—$6,300; $440 each additional person.
Virginia:					
Group I	1,900	2,500	2,900	3,300	5—$3,700; 6—$4,100; 7—$4,500; 8—$5,000; 9—$5,400; 10—$5,900; $500 each additional person.
Group II	1,900	2,500	2,900	3,300	5—$3,800; 6—$4,200; 7—$4,700; 8—$5,300; 9—$5,700; 10—$6,200; $500 each additional person.
Group III	2,100	2,700	3,300	3,800	5—$4,500; 6—$4,900; 7—$5,400; 8—$6,000; 9—$6,400; 10—$6,900; $500 each additional person.
Washington	2,400	3,400	3,800	4,500	5—$5,100; 6—$5,800; 7—$6,500; 8—$7,100; 9—$7,800; 10—$8,400; $660 each additional person.
West Virginia	1,500	2,000	2,100	2,200	5—$2,300; 6—$2,400; 7—$2,500; 8—$2,600; 9—$2,700; 10—$2,800.

Footnotes at end of table.

TABLE 12.—INCOME LEVELS FOR MEDICALLY NEEDY IN TITLE XIX PLANS IN OPERATION AS OF DECEMBER 1974—ANNUAL INCOME[1]—Continued

State	Income protected for maintenance, by number of persons in family				Plus dollars for additional persons
	1	2	3	4	
Wisconsin:					
Area 1	3,400	4,000	4,800	5,600	5—$6,500; 6—$7,200; 7—$7,800; 8—$8,500; 9—$8,900; 10—$9,100; $300 each additional person.
Area 2	3,100	3,800	4,500	5,400	5—$6,300; 6—$6,900; 7—$7,500; 8—$8,300; 9—$8,700; 10—$8,900; $300 each additional person.
Area 3	2,800	3,500	4,200	5,100	5—$6,100; 6—$6,600; 7—$7,200; 8—$8,000; 9—$8,400; 10—$8,600; $300 each additional person.
Area 4	2,800	3,400	4,200	5,000	5—$5,900; 6—$6,600; 7—$7,200; 8—$7,900; 9—$8,300; 10—$8,500; $300 each additional person.

[1] The following 21 States are not listed since they do not include the "medically needy" in the scope of the program: Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Louisiana, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas and Wyoming.
[2] Scale is based on assistance level standards for food, clothing, clothing upkeep and personal care, shelter, school supplies, life insurance and household maintenance. In addition, it includes amounts for minimal personal incidental expenses and the cost of Federal and State income taxes, sales and social security taxes.
[3] FFP in the costs of medical assistance for individuals meeting these standards is not claimed.
[4] Data available for Wayne County.

3. *Mandate automatic coverage of all SSI recipients.*—Some states have used the 209(b) option by which they apply, for purposes of program eligibility, the more restrictive standards in effect prior to implementation of SSI. Certain needy aged persons, as a result, have not qualified for medical assistance under the program.

4. *Equalize benefits across states to the extent that Medicare does not broaden coverage.*

Appendix 2

Statement of John B. Martin, Legislative Consultant to the National Retired Teachers Association and the American Association of Retired Persons

Mister Chairman: My name is John B. Martin and I am here today as Legislative Consultant to the National Retired Teachers Association and the American Association of Retired Persons. We appreciate having this opportunity to express our views on the service gaps and limitations of the Medicare program.

While Medicare has been adequate in defraying a major portion of the costs associated with acute medical care, there are serious omissions which have a detrimental effect on older persons. The lack of coverage for long-term care and the absence of catastrophic protection have a devastating financial impact on those who have inadequate resources. Medicare beneficiaries are also affected in an adverse way by the failure of the program to provide a more complete benefit package which includes such items as: maintenance and preventive services; home health care; and out-of-institution drugs.

Because of time constraints along with the fact that many knowledgeable individuals will also be presenting their views at these hearings, I shall restrict my statement to the issue of out-of-institution drugs. I would like to emphasize, however, that our Associations are equally concerned about the various other limitations of the Medicare program. Ever since the Medicare Act was passed in 1965, numerous efforts have been made by organizations of older Americans, Senators and Congressmen to correct the most glaring deficiency in that federal health program for the elderly; namely, the lack of outpatient prescription drug coverage.

Indeed, the Senate passed drug benefit amendments to Medicare in 1967, 1972 and 1973, only to see those proposals fail to be sustained in conferences with the House of Representatives.

Throughout the past decade, the concept of an outpatient prescription drug benefit under Medicare has enjoyed the support of national, State and local Associations of older Americans, of the HEW Task Force on Prescription Drugs, the 1971 White House Conference on Aging, a Presidential Task Force on Aging, and the Social Security Advisory Council.

Other approaches to providing the elderly with medically necessary drugs have come in recent months in the Senate with the introduction by Senators Edward M. Kennedy, Strom Thurmond and others of the Drug Benefits for the Aged Act of 1977, S. 2144, and the introduction of S. 1479 by Senator Frank Church.

The circumstances which support the need for out-patient prescription drug coverage are these:

The elderly are expanding some 25 cents of each out-of-pocket dollar for drugs and drug sundries. Payments for drugs represent their second highest personal health care expenditure.

Because Medicare does not cover outpatient drugs and because few older Americans purchase or can afford private prescription drug insurance, over 80 percent of the amount spent by the elderly for drugs and drug sundries is paid out-of-pocket.

While comprising less than 11 percent of the nation's population, persons 65 and over account for one-fourth of the total annual prescription drug utilization.

Over 40 percent of the elderly suffer from some form of chronic illness which limits their activity, according to the National Center for Health Statistics. This is twice the incidence of chronic illness among those in their middle years and over five times greater than for younger persons.

The aged spent $72 per person in 1974 for prescription drugs, according to the National Center for Health Statistics, nearly two and one-half times the $30 average per capita expenditure of all age groups. Since many elderly are fortunate enough to get by with no or few prescriptions, this per capita expenditure does not truly reflect the extraordinary out-of-pocket expenditures for drugs by those aged who are chronically ill.

A more meaningful survey of drug users among members of the American Association of Retired Persons and the National Retired Teachers Association in 1973–74 disclosed expenditures of $200 to over $1,000 among the respondents. Amazingly, this represented from 10 percent to as much as 45 percent of their incomes!

Another unfortunate fact is that average individual prescription drug expenditures by those in the two lowest classifications of family income—less than $2,000 and $2,000 to $4,900—are substantially higher than for elderly individuals in higher family income brackets. And I refer here to actual amount of dollars spent, not to a percentage of income.

The amount of drug expenditures compared with income is particularly a problem with an elderly population where fully one-fourth of the individuals are below the near-poverty classification, as shown by an Administration on Aging survey in early 1976. The median personal income of elderly males was $4,961 in 1975; for females, it was $2,642.

Some proponents of a drug benefit for the elderly, whether set up under Medicare or as a separate program with coverage of everyone 65 and over, argue the logic and value of beginning with a program limited to a small, but needy segment of the population as a forerunner to universal coverage under national health insurance. This point of view was ably expressed by Arthur E. Hess, former Deputy Commissioner of the Social Security Administration, in his 1975 paper entitled "Next Steps in Medicare." Mr. Hess wrote:

"There are several reasons for starting with such a limited drug program. First, since there are many serious administrative problems associated with the introduction of a drug benefit, a controlled beginning with a controlled population would provide a base of experienec for developing processing techniques and for assessing administrative costs. Second, program costs would be limited and manageable. Third, the cost of prescription drugs associated with chronic illness represents a known need which is an appreciable portion of the out-of-pocket drug costs of the aged and the disabled. Finally, it would make a significant contribution in the direction of meeting costs of catastrophic illness."

The ironic situation that seems to stymie federal approval of a drug benefit for the elderly is that Congress balks at assisting older Americans in coping with their high prescription drug expenditures because it finds the cost of those expenditures too high.

While the American Association of Retired Persons and National Retired Teachers Association have strongly advocated drug coverage for the elderly for over a decade, we are flexible about the provisions of such a program. With the realization that comprehensive coverage of necessary prescription drugs for some 24 million older Americans could necessitate an expenditure of some three billion dollars, we are properly and primarily concerned that whatever program is devised should feature the most stringent restraints on costs.

An effective and efficient mechanism for establishing a ceiling on reimbursement to pharmacists for the costs of the drug product and their professional service is essential. The Department of Health, Education and Welfare's maximum allowable cost (MAC) program, which has been slow to get under way, is a reasonable step toward this objective. While we have been leading supporters of the MAC program, we have also been vocal advocates for a number of necessary improvements. In the absence of these changes, MAC is far from realizing the full potential of cost savings that our Associations expected from the program and continue to believe are possible.

The primary problem with MAC, in our opinion, is its failure to reach down to the drug manufacturing level with any kind of effective price policy. It makes no sense whatsoever to us to attempt to limit reimbursement payments on drug produtes at the retail level while allowing manufacturers unbridled freedom to market their products at whatever price the traffic will bear and at the wide variations in price for the same product that have shown up in HEW's surveys of pharmacies' invoices.

We believe it is essential that a drug benefit program includes a price policy with respect to manufacturers' wholesale drug prices. Although we are not wedded to any single mechanism, we suggest that a truly effective price policy must guarantee stability in prices for periods of at least six months and must require review or negotiations between the government as payer and the drug firms as providers in order to constrain inflationary price increases.

Our Associations feel the need and necessity of a drug benefit for the elderly, but we also insist that effective cost constraints be made an integral part of such a program.

Our 1977 Legislative Program contains several objectives which relate to cost containment. These are as follows:

1. All federally funded drug programs should be consolidated under a single administrative unit, with the power to negotiate drug prices with manufacturers, set reimbursement payments to providers and grant licenses on patented products when necessary.

2. Federal generic substitution and prescription price posting laws should be enacted.

3. A national formulary of prescription drugs should be published that discloses prices for the purpose of guiding good medical practice and establishing the maximum allowable cost which the government will pay providers under the government programs.

4. A national compendium of drugs should be published.

5. Patent holders of excessively priced drugs, after recovery of research and development costs plus reasonable profit, should be required to license other manufacturers to produce the same product at less cost, receiving back adequate compensation in the form of royalties.

6. A national drug testing and evaluation center should be established to test all new drugs before they are placed on the market.

7. Prescription drug advertising, promotion and sampling should be subject to federal limitations.

8. The universal use of established (generic) names of prescription drugs should be required in prescribing, dispensing, labeling, advertising and promotion.

Another fundamental requirement of a good drug benefit program is public representation. By this we mean that public members are necessary to represent the two most vitally affected constituencies of a drug benefit program: the drug users and the drug payers; that is to say, the patients and the taxpayers. Furthermore, we mean public representation on the planning, policy and administrative levels.

The oversight of federal programs by Congress is a commonplace method of seeking to assure public accountability in the bureaucracy. We do not wish it displaced, but the insight of public representatives participating on planning, policy and program boards will provide a public accountability which, in our opinion, is closer, stronger and more effective. We would not like to see a drug benefit program instituted without it.

If there is wisdom in reaching universal and comprehensive drug coverage in incremental stages, our Associations can support even a scaled down program if the most disadvantaged are initially in it. Those who should comprise this group at least include all citizens 65 years of age and older who are chronically ill. While it might be more desirable to provide free drug coverage, we recognize the likelihood that there may have to be some cost-sharing by patients. If the eventual passage of a bill rides upon such a provision, we could support the inclusion of a minimal co-payment feature.

Whatever drug benefit is enacted, however, should closely articulate with either any future expansion of the Medicare benefit package or the development of a national health insurance program. The net effect of an overall increase in benefits should be the establishment of a more equitable system of health and health-related social care which older persons can afford.

We believe that the elderly's problem with high drug expenditures, besides being due to factors of age and higher incidence of illness, is also in part the employment. retired without adequate pensions, and limited in the amount of earnings they can keep as Social Security beneficiaries. It seems eminently unfair for government and society to discriminate economically against older Americans and then expect them to carry burdens equal to others whose economic opportunities are not so constrained.

These are the major policy goals we seek in a drug benefit program for the elderly. Perhaps, instead of asking ourselves whether the country can afford this program, we should be asking ourselves whether the country can any longer afford not having this program, for reasons of both health and economics. This Committee can add a powerful and influential voice to the dialogue about drug coverage for the elderly which is beginning again to be heard through the halls of Congress. Older Americans need your help.

Thank you.

PREPARED STATEMENT OF SIDNEY SHINDELL, M.D.

My name is Sidney Shindell. I am currently Professor and Chairman of the Department of Preventive Medicine of the Medical College of Wisconsin and for this past year I have served as president of the Association of Teachers of Preventive Medicine. This is an organization comprised of some 600 faculty members in the schools of medicine and schools of Public Health throughout the country concerned wih health promotion and disease prevention. ATPM is represented on the AMA Section Council on Preventive Medicine, is an associate member of the Association of Schools of Public Health, and is the representative of the field of Preventive Medicine in the Council of Academic Societies of the Association of American Medical Colleges.

I come before this subcommittee because of a long-standing concern over the problems of the elderly. In the late 1940's I was in the Division of Chronic Disease of the Public Health Service. Following this, I was director of the Connecticut Commission on the Chronically Ill and Aged. I left this position to work with an American philanthropic organization abroad on a variety of health problems, but principally I dealt with elderly displaced persons in Europe and elderly immigrants to the then newly established State of Israel.

At the time of the enactment of the Medicare legislation, I was back in this country at the University of Pittsburgh, working on developing techniques for utilization review. I have thus been involved in one way or another with problems of the older members of our society over most of my professional career. I do not, however, derive any of my income by rendering direct service to the elderly.

This hearing is devoted to examination of the gaps and limitations in current Medicare coverage, and I would like to address my remarks specifically to these issues. In order to do so, I would first like to make some observations.

The original focus of Medicare a dozen years ago grew out of the concern for services for acute illness. As we all know, simply expanding purchasing power to obtain care for acute illness resulted in an expansion of the delivery system to provide such services. This has been accompanied by a steadily increasing expenditure from tax sources for medical and hospital care.

The increased expenditure is due in part to the steady rise in medical care costs generally, but is also the result of the fact that the principal needs of the elderly are not being addressed.

My problem with the way Medicare operates is that it addresses a very restricted portion of the needs of the elderly and places emphasis at the wrong time and in the wrong place. While it is true that in any one year, one-third of the population 65 and over experiences hospitalization of about 12 days in length, this means that on any one day, only 1% of the aged population is in an acute short-term hospital. And while long-term institutional care is likewise significant in amount, the fact is that only about 5% of the elderly are institutionalized.

Care for acute illness is essential, as is institutional care for those whose physical condition has deteriorated irreparably. However, the major health problem faced by the elderly is neither the acute disease nor irreparabale deterioration. As medical technology has become more and more successful in managing acute episodes, increasingly our problems become those of slowly progressive chronic disabilities. It has taken us some time to realize that if we ever hope to deal with progressive chronic disabilities, we must address them before they reach the stage of hopelessness and incurability. We don't drive our automobiles to the point where they become disabled and then try to fix them; why then do we think that the human body can operate effectively without preventive maintenance?

What I'd like this subcommittee to consider are those resources and services that can contribute to the minimization of progressive deterioration, that can alert us to early evidence of disorder, and that can assist in maintenance of a state of health. I think we should concern ourselves with the 94% of the elderly that are not either hospitalized or institutionalized, and help keep them from needing these facilities.

To get specific: We do not include dental prostheses as a medical benefit, but we're willing to pay the cost of long periods of hospitalization that result from the protein deficiency that may occur because of the inability to obtain an adequate diet. We are unwilling to pay for eyeglasses but undertake to pay the cost of treating a hip fracture that may have been caused by a person tripping over something he or she couldn't see. We are unwilling to pay for hearing aids but are willing to underwrite the cost of both the diagnosis and care of behavioral aberrations that may be traceable to communication difficulties. In each case we've refused an expenditure of a few hundred dollars and have been required therefore to pay out several thousand.

Much evidence has been available for at least twenty years that adequate day care service is effective in minimizing the need for institutionalization in a significant number of elderly. Evidence also has been available that adequate physical therapy services in institutions can reduce the incidence of incontinence and hence the need for nursing care, yet our current funding restrictions place a distincentive on these services.

Screening programs for diabetes, hypertension, glaucoma, and a variety of other conditions have demonstrated that incipient disease is present in a significant number of elderly, yet Medicare benefits are available only for the care of frank disease, not for programs designed to deal with general health improvement, nutrition, activity level, stress, and adjustment to change.

Let me say that screening without follow-through is of little utility. It's like bidding a bridge hand and then not being able to play the hand. It's only half the game. Screening has to be looked on as the beginning of a management plan, not an end in itself. This is true of periodic physical exams as well. Unless one makes provision to assist the participant in a screening program, follow-through on findings that represent not only current threats but are harbingers of future difficulty, there is little utility in doing the initial appraisal. Unless one is prepared to finish a job, there is little utility in starting it.

Partial service is wasteful. It is wasteful because it gets repeated over and over again. I can only plead for follow-through so that we can do what we know can be done.

I don't for the moment suggest we have all the answers. What we do know is that the current system provides no incentives to use the answers we do have or to develop better ones than those current available. We also have a suggestion to offer for consideration.

I'm sure you are concerned about how we might reduce hospitalization and institutionalization without incurring added costs not accompanied by concomitant benefits. We know that deductibles and co-insurance are not the answer. The aged are still expanding out-of pocket essentially what they did when Medicare was enacted, i.e., about 8% of their gross income. Just like the focus of care, the focus of disincentive appears to be in the wrong place.

I suggest that each person eligible for Medicare register with a primary health care provider, i.e., a physician or clinic facility so that someone would be responsible for helping the aged individual with total health management. This should be paid by Medicare and should be on an annual basis, regardless of the specific services rendered. For an annual amount representing less than the cost of one day's hospitalization, the health care provider selected by the Medicare-eligible person could do a periodic health assessment specifically suitable for that individual and work with him or her on a comprehensive plan for health promotion and health maintenance.

Because one is managing a total health plan, the cost of using services on an uncoordinated basis should be significantly reduced.

Any further service needed beyond the overall health maintenance activity would require the authorization of the selected provider. Glasses could be authorized if needed for safe vision, dentures if needed for adequate nutrition, and the like. Such a person or agency could also be required to concur in any plan for hospitalization or for any complex diagnostic study or any surgical procedure. In order to avoid conflict in interest, the person or agency responsible for overall health maintenance might be precluded from either performing specialized diagnostic studies or surgical procedures. It might even be suggested that a portion of the health maintenance fee be returned if hospitalization actually occurs during a specified period.

I would like to see a relationship built between the provider and the individual Medicare-eligible citizen that epitomizes the most desirable aspects of the doctor-patient relationship, with free choice of selection, and no incentive for either

unnecessary service or hospitalization. I would similarly like to see such a health maintenance manager and the individual participating in a health maintenance plan be free to utilize community services designed to help deal with physical and psychological needs of our older citizens. These would include community active programs, day care services, and the like. The cost of such services should also be borne by Medicare.

We all know that even if we did all these things we would not solve all the problems of the elderly. Loneliness as contemporaries die, reduction of income, lessened mobility, fear of safety, difficulty in obtaining transportation, would all remain to be dealt with. With improved health, however, some of these can be dealt with more easily.

The sum and substance of what I've been trying to say is this:

The one inexorable statistic is that 100% of the people will die 100% of the time. The only meaningful issues are when, and from what. I'm suggesting that we pay attention to those things that can contribute to health and a sense of well-being so that one's declining years can be as free of discomfort and disability as we can accomplish.

Highlights of Testimony of Dr. Sidney Shindell

Much attention is being paid today to "death with dignity." I'm suggesting that dignity in living should be of equal concern. We are spending money to help people die. I'd like to see some spent to help them live. I believe we can do so with timely intervention. I believe we can do so if we expand some effort in developing a mechanism that is designed to try.

(1) Current Medicare coverage is directed toward hospitalization for acute illness and long-term care for people with irreparable deterioration.

(2) Health services for elderly should be directed at maintaining health and retarding progress of chronic disease states.

(3) A program of preventive health maintenance is the only way to forestall need for hospitalization and long-term institutional care.

(4) A program of total health management on a capitation basis is suggested in order to accomplish health status appraisal, coordinate needed services, and control unnecessary use of hospitals and long-term institutions.

(5) Rational for funding of dental prostheses, eyeglasses, hearing aids and community-based activity and counselling programs is also presented.

Statement of the Mental Health Association on Discrimination Against the Mentally Ill in Medicare

SUBMITTED BY HILDA ROBBINS FOR THE MENTAL HEALTH ASSOCIATION

Digest

I. INFORMATION ON THE WITNESS

Hilda Robbins is a resident of Fort Washington, Pennsylvania. She is testifying on behalf of the Mental Health Association, of which she is a candidate for President Elect. Mrs. Robbins is Chairwoman of the MHA National Committee on Legislation and Services.

THE MENTALLY ILL

A. Part A, Hospital Insurance, places a lifetime limit of 190 benefit days on patients in psychiatric hospitals; no such limit is placed on patients in other hospitals. Additionally, if the beneficiary is a patient in a mental hospital when his Medicare coverage begins, the number of days he has been in the hospital is deducted from his first benefit period; no such deduction is made in the case of patients in other hospitals.

B. Part B, Medical Insurance, limits reimbursement for mental illness to 50 percent of expenses; for all other illnesses, the reimbursement is 80 percent. Additionally, the maximum reimbursement for mental illness in any one year is $250; there is no maximum for other illnesses.

C. Congress has created a nationwide network of Community Mental Health Centers (CMHCs) and has mandated that they serve the elderly, yet many of these centers are not recognized by Medicare as qualified service providers.

D. The discrimination against the elderly mentally ill also works against the mentally ill of other ages. Many of the pending National Health Insurance bills either incorporate Medicare or pattern their benefits after it. Moreover, many private health insurance policies follow the discriminatory pattern set by Medicare.

III. RECOMMENDATIONS FOR ENDING DISCRIMINATION AGAINST THE MENTALLY ILL IN MEDICARE

A. Repeal Section 1812(b)(3) and Section 1812(c) of the Social Security Act to eliminate the discrimination in Part A.

B. Repeal Section 1833(c) of the Social Security Act to eliminate the discrimination in Part B.

C. Amend both Parts A and B to recognize Community Mental Health Centers as qualified providers of service under the Medicare program.

IV. SUMMARY

The discrimination against the mentally ill as written into Title XVIII. Medicare, of the Social Security Act is totally unwarranted and should be ended forthwith.

V. ATTACHMENTS

Attachment 1. Section 1812 of the Social Security Act (as in 42 USCA 1395d).

Attachment 2. Sections 11128-11138 of the Social Security Administration Claims Manual.

Attachment 3. Section 1833 of the Social Security Act (as in 42 USCA 1395*L*).

Attachment 4. Sections 11374 and 11380–11384 of the Social Security Administration Claims Manual.

Attachment 5. Graph illustrating Medicare, Part B.

Attachment 6. Extract from Community Mental Health Centers News, February, 1976.

Attachment 7. Extract from House Report 94–192, May 7, 1975.

Attachment 8. Article, "Health Insurance for Older People—Filling in the Gaps in Medicare," *Consumers Reports*, January, 1976.

STATEMENT OF HILDA ROBBINS FOR THE MENTAL HEALTH ASSOCIATION

Mr. Chairman and Members of the Subcommittee: My name is Hilda Robbins. I am testifying for the Mental Health Association, National Headquarters. I have worked as a volunteer in the mental health field for twenty-two years, working first with long-term women patients at Norristown (Pennsylvania) State Hospital. Later I was president of the local and then the state mental health association and a vice president of national. My keenest interest has always been in the areas of legislation and delivery systems. I pursued this interest as chairwoman of the legislative committees of the local, the state and the national mental health associations. And as a citizen/consumer I am currently a member of the Montgomery County (Pennsylvania) Mental Health/Mental Retardation Board, the Pennsylvania Mental Health/Mental Retardation Advisory Committee and the National Advisory Mental Health Council. I am a candidate for President Elect of the Mental Health Association.

We are very grateful for this opportunity to present our views to the Health and Long-Term Care Subcommittee of the House Select Committee on Aging.

This testimony is designed to illustrate how the Medicare program, Title XVIII of the Social Security Act, created by Congress to assist that part of the population which is 65 years of age and over, discriminates against one specific segment of that population, the mentally ill, and to urge the members of this Committee to take the initiative in ending the discrimination.

Let me begin by quoting one sentence from an editorial in the February 21, 1976, issue of the *Saturday Review*. The entire issue is devoted to mental illness and the editor, Norman Cousins, in talking about the mentally ill, concludes that:

"No other group of Americans—not blacks nor senior citizens or members of religious minorities—is more victimized by discrimination."

He could have added that of all the mentally ill, no other group is more discriminated against than the elderly—and by their own Government.

The discrimination of Medicare against the mentally ill does not lie in its administration or in some arbitrary regulations drawn up in the vast HEW bureaucracy. The discrimination is written into the law, Title XVIII of the Social Security Act as passed by Congress in 1965. Title XVIII is that part of the Social Security program that provides hospital and medical insurance to social security participants and a few others aged 65 and over. Part A of Title XVIII provides hospital insurance. Participants are automatically covered on reaching age 65. There are no premiums. Part B is medical insurance; that is, doctor bills and the like. It is optional and requires the payment of monthly premiums. Parts A and B together comprise the Medicare program.

Wherein is the discrimination against the mentally ill? Under Part A, hospital insurance, the beneficiary is covered for a certain number of days each time he or she enters a hospital. The beneficiary may return to the hospital as many times as is necessary for the rest of his life, as long as there is a break of 60 days between hospital stays, and still be covered by Medicare—unless he or she is a patient in a psychiatric hospital. If the beneficiary is a patient in a psychiatric hospital rather than a general hospital, there is a life-time limit of 190 days of coverage under Medicare. To repeat: there is no limit to the number of times the beneficiary may be treated in a general hospital, but there is a lifetime limit of 190 days in a psychiatric hospital. This is blatant discrimination against the mentally ill, written into law by the United States Congress.

Moreover, if the beneficiary is a patient in a psychiatric hospital at the time he becomes eligible for Medicare, the number of days he has already spent in the hospital is deducted from his initial benefit period. No such deduction is made against the patient who happens to be in a general hospital when his Medicare coverage begins. This too is blatant discrimination against the mentally ill. And in our view, it is totally unwarranted.

These inequities could be eliminated by the very simple device of striking the limitations from the law as it now stands. We urge the members of this committee, with your avowed dedication to our elderly citizens, to take the initiative and introduce legislation toward that end.

I am including with my statement, as Attachment 1, a copy of Section 1812 of Public Law 89–97. See specifically 1812(b)(3) and 1812(c). I include as Attachment 2 Sections 11128–11138 of the Social Security Administration Claims Manual, which instructs the field offices in how to apply these limitations.

I now turn to Part B, medical insurance. Part B of Medicare provides that, for those who choose to subscribe, the Government will pay 80 percent of allowable doctor bills and related medical expenses (apart from hospital costs under Part A) after a deductible of $60 per year. Once the deductible has been met, there is no limit to the amount of reimbursement in any one year—unless the diagnosis is "mental, psychoneurotic, and personality disorder", in other words, mental illness. If the diagnosis is mental illness, the absolute maximum reimbursement in any one year is $250. This is gross discrimination against the elderly mentally ill.

Moreover, whereas medical bills, assuming they are reasonable and otherwise proper, for all other illness are honored at face value. Part B of Title XVIII states that the allowable cost for treatment of a "mental, psychoneurotic, and personality disorder" shall be only 62½ percent of the actual cost. What this boils down to is that for all other illnesses Medicare pays 80 percent after the deductible, but for mental illness pays only 50 percent (80 percent of 62½ percent) and then only up to a ceiling of $250. And, if the deductible is all for mental illness—that is, includes no bills for flu, broken bones, etc.—the ceiling is not even $250; it is $202.

The Mental Health Association resents this cruel and arbitrary discrimination against the mentally ill and calls upon the members of this committee to eliminate it. The cure is simple: strike paragraph (c) from Section 1833 of Public Law 89–97, as amended.

I include as Attachment 3 a copy of Section 1833 and, as Attachment 4, Sections 11374 and 11380–11384 of the implementing Social Security Administration Claims Manual. I am also including a graph, as Attachment 5, which shows the actual dollar impact of these Part B limitations.

Thus far I have discussed only those limitations which were purposely written into law. There are others, however, which although presumably unintentional are more invidious. One of these is the equating of inpatient care with hospitalization, as Title XVIII does. Since Medicare was first proposed, there has evolved in this country a whole new concept for treating the mentally ill. The emphasis is away from long-term commitment to a huge and often remote hospital, and toward quick, intensive care in small community centers.

The Congress itself has been very mindful of this in providing Federal seed money for community mental health centers. It was just last July that the Congress overrode the President's veto of the bill renewing and overhauling the CMHC program. Let me quote briefly from Section 301 of the renewal act, Public Law 94–63:

"The Congress finds that (1) community mental health care is the most effective and humane form of care for a majority of mentally ill individuals; (2) the federally funded community mental health centers have had a major impact on the improvement of mental health care . . . and thus are a national resource to which all Americans should enjoy access . . ."

Moreover, Congress wrote into Public Law 94–63 the express requirement that every such center must—may not; must—serve the elderly as well as other age groups. Yet the very centers Congress has helped create and has now directed to serve the elderly are often unable to qualify as providers of inpatient services under Medicare. Only 58 percent of all centers, based on a 1975 sampling of 178 centers, are being reimbursed by Medicare for inpatient services. Of this 58 percent, 96 percent of the centers operated by hospitals are being reimbursed, 67 percent of those affiliated with, but not operated by, a hospital are being reimbursed, and only 16 percent of the free-standing centers are being reimbursed by Medicare for inpatient services—notwithstanding the fact that every one of the centers must satisfy HEW that they are meeting the standards and performing the services required by Congress in the CMHC Act. (For additional information, see Attachment 6.)

The paradox is more striking when viewed in the light of the House Report on the 1975 amendments. The report is highly critical of both HEW and the centers themselves for their poor performance in helping to finance their operations through third party payments, especially from Medicare and Medicaid, although the report does recognize the problem I am describing. (Pages 58–60 of House Report 94–192, May 7, 1975, are included as Attachment 7.)

The paradox is even more striking when it is realized that the average cos per inpatient day in community mental health centers in 1972 was $66.30, a against $71.53 in private psychiatric hospitals, and $112.00 in general hospital (It should be emphasized that these are 1972, not 1976, costs.)

To remedy this discrimination against the elderly mentally ill we recommen that Congress amend Title XVIII to recognize federally funded mental healt centers, and any others which although not federally funded meet comparabl standards to the satisfaction of HEW, as qualified providers of inpatient service for the mentally ill.

Another stumbling block is a provision in Part B which limits reimbursemen for outpatient services by clinics (vis-a-vis hospitals on the one hand and sol practitioners on the other) to those services provided only while a physician i on the premises. The physician does not have to see the patient; it is require only that he be on the premises. In the field of mental health, physicians—notabl psychiatrists—are but one of the many disciplines useful in combating menta illness. Others include clinical psychologists, of course, and psychiatric socia workers, nurses, and various other specialists. Every mental health center has on or more physicians on its staff but as often as not, while there might be as man as a dozen licensed physicians on the staff, the physicians are part-time em ployees. Seldom is one on the premises around the clock. And the hallmark of community mental health center is that it is open twenty-four hours a day, seve days a week. Additionally, many community centers have developed satellit centers, small branches located in outlying parts of their service areas. A phys cian is an indispensable member of the mental health center team, but he ce tainly cannot be in all places at all times.

An amendment recognizing community mental health centers as qualified pr viders of outpatient services, as I have already proposed in regard to inpatien services, should also overcome this limitation.

May I also point out yet another aspect of discrimination against the elderl mentally ill. Most of the national health insurance bills now pending in the 94t Congress would incorporate, either permanently or during a phasing-in perio either in whole or in part, Title XVIII of the Social Security Act as it no stands. (See HR 1, HR 93, HR 363, HR 2049, HR 5990, HR 6222, and HR 10028. In other words, Medicare, with all its benefits and all its shortcomings, is th model. If Medicare is to be the model, then by all means let us first amend it t wipe out any and all discrimination against the mentally ill.

I would be remiss if I left the impression that the Federal government alon discriminates against the mentally ill. This is not the case. While there has bee tremendous improvement in the inclusion of mental health coverage in privat health insurance policies in the recent past, especially in group policies, man private health insurance policies are still more discriminatory than Medicar An article in the January 1976 issue of Consumer Reports covered the so-calle "Medigap" policies; that is, insurance which takes up where Medicare leaves of Nine of the 14 hospital and/or medical insurance plans analyzed—including 4 o the 5 promoted by the American Association of Retired Persons—pay absolutel nothing if the diagnosis is mental illness. Of the seven which pay anything at al the amounts are pathetically small, being limited in most cases to the deductibl and the co-insurance not paid by Part B of Medicare. I enclose, as Attachment the article entitled "Health Insurance for Older People—Filling the Gaps i Medicare", from the January 1976 Consumer Reports.

This concludes my formal presentation. We appreciate the opportunity of ap pearing before this committee, and I will be glad to try to answer any question you may have. Finally, I promise you that the Mental Health Association is goin to do all in its power to bring to an end the discrimination against the elderl mentally ill as set forth in the current Medicare law, Title XVIII of the Socia Security Act. We hope we can count on the full support of every member of thi Select Committee on Aging.

Thank you.

ATTACHMENT 1

Medicare, Part A. Section 1812 of the Social Security Act (as set forth in 42 USCA 1395d).

§ 1395d. Scope of benefits

(a) The benefits provided to an individual by the insurance program unde this part shall consist of entitlement to have payment made on his behalf or, in th case of payments referred to in section 1395f(d) (2) of this title to him (subject t the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made) ;

(2) post-hospital extended care services for up to 100 days during any spell of illness ; and

(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1395x(n) of this title) after the beginning of one spell of illness and before the beginning of the next.

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c) of this section) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made) ;

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell ; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) of this section insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b) (3) of this section).

ATTACHMENT 2

Medicare, Part A. Social Security Administration Claims Manual, Sections 11128 through 11138.

PSYCHIATRIC REDUCTION

11128. Inpatient Psychiatric Reduction.—

(*a*) *General.*—If an individual is in a participating psychiatric hospital on the first day of his entitlement to hospital insurance, the number of inpatient benefit days in the first benefit period is subject to reduction. The days (not necessarily consecutive) on which he was an inpatient of a psychiatric hospital in the 150-day period immediately before the first day of entitlement, must be subtracted from the 150 days of inpatient hospital services for which he would otherwise be eligible in his first benefit period. Days spent in a *general hospital* for diagnosis or treatment of a psychiatric condition prior to entitlement will not reduce the patient's inpatient benefit days in his initial benefit period.

The reduction applies only to inpatient hospital services received in a psychiatric hospital, or in a general hospital if the individual is an inpatient of the general hosptal primarily for the diagnosis or treatment of mental illness. Thus, for example, if a patient in a psychiatric hospital has no benefit days remaining because of the reduction, he may nevertheless be entitled to have payment made for up to 150 days in inpatient hospital services for a non-mental illness during his first benefit period.

(*b*) *Determining Days Available.*—The patient will be eligible to have payment made for inpatient psychiatric hospital services and inpatient hospital services primarily for the diagnosis or treatment of mental illness in the first benefit period only for the number of days remaining after the reduction is applied. To determine the number of days available in the first benefit period to pay for inpatient psychiatric hospital services and inpatient hospital services for the treatment of mental illness, the following steps are taken :

(1) determine how many days in the 150-day preentitlement period the patient spent in a psychiatric hospital.

(2) subtract these from 150.

Payment is made for the remaining days in the following order of priority:

(A) the 60 full benefit days,

(B) the 30 coinsurance days at one quarter the inpatient hospital deductible,

(C) the 60 lifetime reserve days at one half the inpatient hospital deductible.

Benefit days, including lifetime days, not available to the patient because of the psychiatric reduction nevertheless remain available for use in hospitalization not subject to the reduction: a general hospital stay for a nonpsychiatric condition or a tuberculosis hospital stay. The lifetime days not previously used also remain available for any inpatient stays (including psychiatric hospital stays) in subsequent benefit periods.

EXAMPLE 1: The patient was an inpatient of a participating psychiatric hospital on his first day of entitlement on February 1, 1970. He had been in such a hospital in the preentitlement period for 20 days. Therefore, 130 days are payable. Payment would be made in the following order: 60 full benefit days; 30 $13 coinsurance days; 40 $26 coinsurance (lifetime) days.

EXAMPLE 2: The same facts as example 1, except that the patient had been in a psychiatric hospital in the preentitlement period for 70 days. Therefore, 80 days are payable. Payment would be made in the following order: 60 full benefit days; 20 $13 coinsurance days.

EXAMPLE 3: The same facts as an example 1, except that the patient had been in a psychiatric hospital in the preentitlement period for 110 days. Therefore, 40 days are payable. Payment would be made for these 40 days at full benefit.

11130. Patient's Status in Applying Reduction.—A patient who is in a participating psychiatric hospital on the first day of his entitlement is subject to the inpatient psychiatric reduction. The restriction applies to patients admitted to or discharged from such a hospital on their first day of entitlement, or who begin or end a leave of absence on that day. Where only a distinct part of an institution is participating as a psychiatric hospital, the provision applies only to patients who, on their day of entitlement, are inpatients of that part.

The provision does not apply to persons who are receiving inpatient diagnostic or therapeutic services for a psychiatric condition in a general hospital on their first day of entitlement. It also does not apply to patients who, on that day, are inpatients of a psychiatric institution's medical-surgical facility, if that facility is participating as a general hospital.

11132. Institution's Status in Determining Reduction in Days.—The status of a psychiatric hospital (or a distinct part of such a hospital) as of the individual's first day of entitlement is controlling in determining whether days spent there during the preceding 150 days are to be deducted. Thus, deductions would be made for days spent in a hospital (or distinct part) which was participating as of the individual's first day of entitlement even though it was not participating during all or part of the preceding 150 days. However, where an institution is not participating as of the individual's first day of entitlement, deductions would not be made for days spent in that institution during the preceding 150 days, even though the institution is later certified for participation as a psychiatric hospital.

Where a participating psychiatric hospital is a distinct part of an institution, deductions are made only for days spent in the wards, floors, wings, etc., included in the participating distinct part as of the individual's first day of entitlement, even though it was not participating during all or part of the preceding days. Deductions are not made for days spent in a part of the institution not included in the participating distinct part as of the individual's first day of entitlement; e.g., days spent in a custodial section of the institution or days spent in a general medical-surgical facility participating as a general hospital.

11134. Counting Days of Admission, Discharge, and Leave in Reducing Days.—In determining the number of days to be deducted, days of admission and days on which the patient returned from leave of absence are included. Days of discharge, days on which the patient began a leave of absence, or days of leave during all of which the individual is absent from the hospital are not counted.

11136. Inpatient Psychiatric Hospital Services—Lifetime Limitation.—Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. *The limitation applies only to services furnished in a psychiatric hospital.* The period spent in a psychiatric hospital

prior to entitlement does not count against the patient's lifetime limitation, even though preentitlement days may have been counted against the 150 days of eligibility in the first benefit period.

11138. Inpatient Service Days Counting Toward Maximums.—Inpatient hospital (including psychiatric and tuberculosis hospitals) services count toward the maximum number of benefit days payable per benefit period only if:

(a) payment for the services is made, or

(b) payment for the services would be made if a request for payment were properly filed.

However, where payment cannot be made because of the inpatient deductible or coinsurance requirement, the inpatient day(s) used in satisfying these requirements nevertheless counts toward the beneficiary's maximum inpatient days.

Similarly, inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if these conditions are met.

ATTACHMENT 3

Medicare. Part B. Section 1833 of the Social Security Act (as set forth in 42 USCA 1395l).

§ 1395l. Payment of benefits—Amounts

(a) Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k(a)(1) of this title—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b) of this section, (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1395(a)(4) of this title, the amounts paid shall be subject to such limitations as may be prescribed by regulations, and (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section); and

(2) in the case of services described in section 1395k(a)(2) of this title—with respect to home health services, 100 percent, and with respect to other services, 80 percent of—

(A) the lesser of (i) the reasonable cost of such services, as determined under section 1395x(v) of this title, or (ii) the customary charges with respect to such services; or

(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title; or

(C) if such services are services to which the next to last sentence of section 1395x(p) of this title applies, the reasonable charges for such services.

DEDUCTIBLE PROVISION

(b) Before applying subsection (a) of this section with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) of this section are determinable) shall be reduced by a deductible

of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the succeeding calendar year and applied toward such individual's deductible under this section for such preceding year, and (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

MENTAL DISORDERS

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) of this section only whichever of the following amounts is the smaller:

(1) $312.50, or

(2) 62½ percent of such expenses.

NONDUPLICATION OF PAYMENTS

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individuals is entitled (or would be entitled except for section 1395e of this title) to have payment made with respect to such services under part A of this subchapter.

INFORMATION FOR DETERMINATION OF AMOUNTS DUE

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

ATTACHMENT 4

Medicare, Part B. Social Security Administration Claims Manual, Sections 11374 and 11390–11394.

DEDUCTIBLES, COINSURANCE, PSYCHIATRIC LIMITATION

11374. Deductible

For expenses incurred after 1972 a deductible of $60 must be satisfied in each calendar year before payment may be made under SMI. Bills count toward the deductible on the basis of incurred rather than paid expenses and are subject to a reasonable charge (see § 11227) determination. Covered expenses incurred in the last three months of the previous year, which were applied toward the medical insurance deductible for that year, may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial SMI expenses incurred in the current year.

The date of service determines when expenses were incurred, but expenses will be allocated to the deductible in the order in which the bills for those expenses are received by the carrier. An adjustment will be made when expenses incurred

in the fourth quarter of one year are used to satisfy the deductible for the following year and is subsequently determined that the patient had incurred covered expenses prior to the fourth quarter of the earlier year.

Even though an individual is not eligible for the entire calendar year; i.e., his coverage begins after the first month of the year, he must nevertheless, satisfy the full $60 deductible.

Expenses incurred under the provision for 100 percent reimbursement for radiological and pathological services to hospital inpatients do not count toward the deductible.

113S0. Coinsurance

After the deductible has been satisfied, providers will be paid 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. When payment is made on the patient's behalf, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services furnished.

The coinsurance requirement was eliminated for home health services provided on or after 1/1/73.

113S1. Psychiatric Services Limitations—Expenses Incurred for Physicians' Services

Regardless of the actual expenses for physicians' services incurred for treatment for mental psychoneurotic or personality disorders (see § 113S3) of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of $312.50 or 62.5 percent of the actual expenses. The computation of psychiatric expenses for deductible purposes is also subject to the 62.5 percent rule. Since $312.50 represents 62.5 percent of $500. any amount of noninpatient psychiatric service expense in excess of $500 would not be considered in computing incurred expenses subject to reimbursement. Since the program's share of covered incurred expenses (after the $60 deductible) is 80 percent of the charges, the maximum possible payment for services would be 80 percent of $312.50 or $250. This maximum could be reached only if the individual has had $60 of incurred expenses other than noninpatient psychiatric service expenses. When the beneficiary does not have any incurred expenses other than the noninpatient psychiatric service expenses, the maximum possible payment by the program is $202.

113S2. Psychiatric Services Limitation Computation

To compute the benefit:

(*a*) Consider all psychiatric expenses incurred, up to a maximum of $500, whether or not applied to the deductible.

(*b*) Multiply by .625.

(*c*) Subtract any unsatisfied deductible.

(*d*) Multiply by .8.

Example 1: In 1974, patient C had psychiatric treatment while not an inpatient and incurred total expenses of $600. The benefit payable is computed as follows: $500 (maximum incurred expenses) X.625=$312.50. Since no part of the deductible has been satisfied for the year, subtract $60, leaving $252.50. The benefit payable is $202 (80 percent of $252.50.)

Example 2: Assume total psychiatric expenses while not an inpatient to be $800. and $25 of nonpsychiatric expenses had previously been incurred and applied toward the deductible. The benefit payable is computed: $500 (maximum incurred expenses) X .625–$312.50. Since $25 of the deductible has already been satisfied, subtract $35, leaving $277.50. The benefit payable is $222 (80 percent of $277.50).

Example 3: A beneficiary is receiving psychiatric treatment during 1974. He visits the psychiatrist's office once a week and the charge for each visit is $25. After 16 weeks his total bill for services through October 20 is $400. On that date he is hospitalized for an acute mental disturbance and continues to receive treatment through the end of the year. An SSA–1490 for 1974 in Part B charges is submitted. There are no other Part B medical expenses during the year. The total bill for services while the beneficiary was not an inpatient is $400. Sixty-two and one-half percent of this amount is $250. After subtraction of the deductible, 80 percent of the $190 balance can be paid. Since the remaining $250 (10 weeks at $25 a week) in Part B charges were for services while the beneficiary was an inpatient, 80 percent of this amount may be paid as if they were regular medical (nonpsychiatric) expenses.

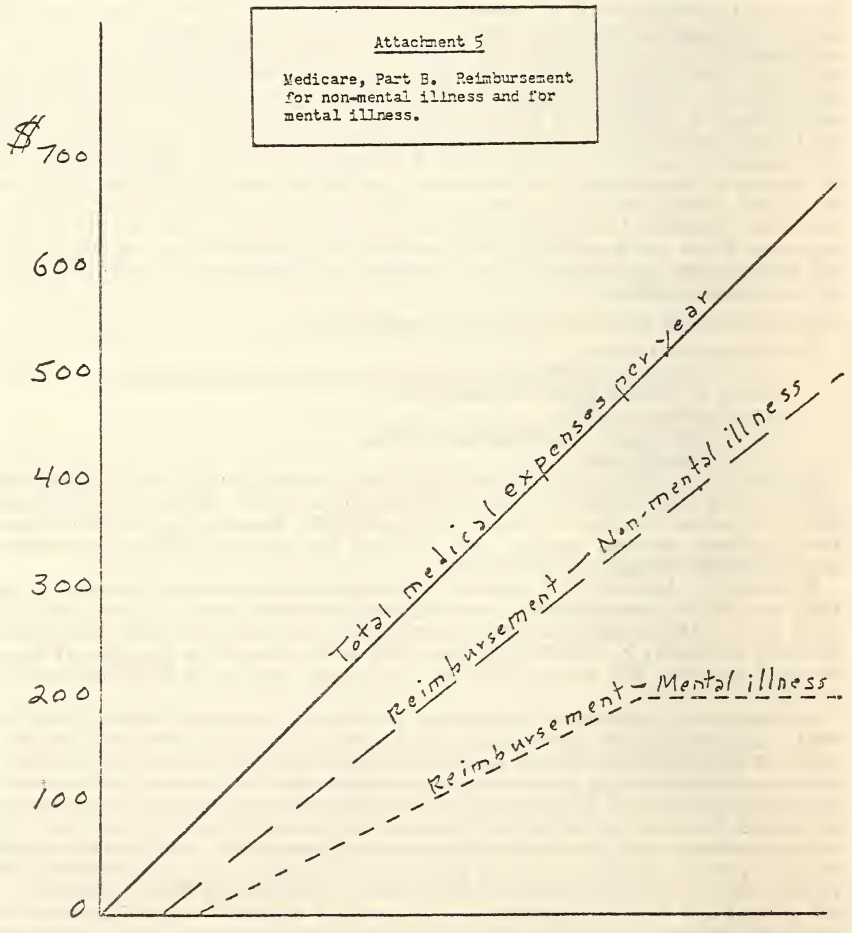
11383. Application of the Limitation

The term "mental psychoneurotic, and personality disorders," is defined as the specific psychiatric conditions described in the American Psychiatric Association's *Diagnostic and Statistical Manual-Mental Disorders*. The limitation applies only to expenses incurred for physician's services rendered in connection with one of these psychiatric conditions (with no distinction being made between the services of psychiatrists and nonpsychiatric physicians), and any items or supplies furnished by the physician in his own office. Services furnished by other health personnel including home health services and outpatient hospital health personnel would not be subject to the special psychiatric limitation even though the services are in connection with a condition included in the definition of "mental, psychoneurotic, and personality disorders."

The Act specifies that the limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation is applicable to services furnished by a physican in outpatient departments, in a physician's office, the patient's home, in SNF's, etc.

11384. Determining When the Limitation Applies

When the physicians' services were rendered for both a psychiatric and one or more nonpsychiatric conditions, the carrier will separate the charges for the psychiatric aspects of treatment from the nonpsychiatric charges.



Attachment 6 retained in Committee files.

ATTACHMENT 7

House Report No. 94–192, May 8, 1975, to accompany H.R. 4925. The companion bill S. 66 became Public Law 94–63, which renews and extends the Community Mental Health Centers Program.

General Provisions Affecting Grants

The bill sets a number of application requirements for planning, initial operating, consultation and education, conversion, and facility grants, including a number of requirements designed to ensure that CMHC's become self-sufficient wherever possible.

The Committee bill requires that each CMHC must make more strenuous efforts to obtain reimbursements for direct services rendered to Medicare and Medicaid beneficiaries. The Committee is disturbed that less than 6 percent of all funds received by CMHC's in 1972 were derived from the Medicaid program even though over 42 percent of the patients served were in families with incomes of less than $2,500 and almost two-thirds had incomes of less than $5,000. One factor contributing to the low level of Medicaid reimbursements, the Committee concludes, derives from the failure of many State Medicaid programs to include services provided by free-standing clinics in their state plans. In this regard, the Committee intends to give careful consideration to legislation proposed by the Administration which would make "clinic services" a mandatory part of each State's Medicaid plan. Positive action by the Congress on this proposal would substantially increase payments to CMHC's and enable a significant reduction in categorical funding.

The Committee is also concerned by reports that CMHC's are not receiving payment for services from those who are able to pay for part or all of the cost of treatment. In total, patient fees and insurance payments amounts to less than 12 percent of total revenues. The Committee, therefore, has included a requirement that each center establish an equitable and reasonable fee system for services.

The Committee also wishes to emphasize that the federal CMHC grant program is not intended to subsidize other Federal third party payment programs, such as Medicare. Medicaid and the social services programs authorized under the Social Security Act. The Committee is disturbed by reports that the Secretary intends to require federally funded CMHC's to deduct their Federal grant under this Act, before calculating the costs of social services for reimbursement purposes. Such a procedure severely handicaps the CMHC's capability of achieving self-sufficiency and prevents the development of realistic accounting systems thus disrupting the CMHC's efforts to obtain other third party payments. Under the new legislation, CHMC's are required to bill social services, Medicare and Medicaid on the basis of the full cost of services. Thus, this HEW policy is in direct conflict with the provisions in this legislation.

Finally, the bill requires HEW to provide technical assistance and training in fiscal and program management to grant applicants. This assistance is intended to ensure that the operations of centers, particularly their financial management and cost-accounting procedures, are sufficiently improved to achieve maximum reimbursements through patient fees and third party payments. Although efforts to provide such technical assistance are now being expanded in the Department, this action is belated and has not yet proved to be effective. The Committee expects the Secretary to increase technical assistance to existing programs, while at the same time requiring that all new programs have sound fiscal and program management systems.

The Committee recognizes, however, that constraints to increasing reimbursements exist which are beyond the control of individual CMHC's to ameliorate.

1. Free-standing CMHC's are not certified as "providers" under Part A of the Medicare program.

2. Medicare and most private insurers reimburse centers for physician services but not for other program costs.

3. Third party payors discriminate against the psychiatric patient by severe limitations on the number of outpatient visits reimbursable under the policy.

4. A high percentage of CMHC patients have incomes too low to purchase insurance with adequate mental health benefits, but too high to qualify them for public medical assistance programs.

Until these constraints are eliminated and CMHC's improve their own capability to fully collect monies to which they are entitled, third party reimbursements will remain insufficient to cover the cost of psychiatric services delivered in CMHCs.

The Committee, in recognition of the underutilized opportunities available to CMHC's as well as the uncontrollable constraints facing them, has adopted the following position on non-Federal reimbursements:

1. Federal grant funds are to be viewed as supplementing reimbursements from third party insurers, State and local funds, patient fees and other Federal health care financing programs such as Medicare, Medicaid and Social Services under title XX of the Social Security Act.

2. Federal grant funds will not be used to supplant State, local, other Federal and non-Federal funds.

3. The Secretary may *not* disapprove an application or reduce the Federal grant level on the grounds of inadequate effort by the CMHC to obtain reimbursements unless the Secretary affords the CMHC the opportunity for a hearing and obtains the recommendations of the National Mental Health Advisory Council.

In addition, the bill proposes, as conditions for receiving grants, a number of requirements consistent with the "conditions of participation" required of institutional providers under Part A of Medicare.

These requirements are designed to emphasize the Committee's objectives that CMHC's become independent of Federal support in an orderly and reasonable manner without the precipitous and counterproductive cut-offs and reductions proposed by the Administration which disrupt normal operations and retard full growth and development.

Attachment 8 retained in Committee files.

ATTACHMENT 9

Answers to questions asked by Chairman Cohen during oral testimony.

Question. What is the average cost for an elderly patient receiving mental health care and how many elderly fall under that category?

Answer. A survey of 800 mental health clinics reveals that the average cost of care for all ages is $435 per person. Since the elderly use these facilities less, and their time of treatment is shorter, the cost would be somewhat less for the average elderly person.

Estimates for the number of elderly patients using these facilities on an outpatient basis are as follows:

Community mental health centers	37,000
Outpatient Psychiatric Clinics	53,000
Others—	
Veterans Administration Hospitals and private practice	90,000
Total	180,000

Question. What is the average length of stay for an elderly patient in inpatient facilities?

Answer. The following data is compiled on a median basis:

	Days
State and county mental hospital	53.2
Private psychiatric hospital	21.4
General hospital inpatient facilities	17.6

Question. Do you have any statistics you can provide the committee with the relationship, if any, between poverty and mental illness among the elderly?

Answer. Older people generally have less money than younger people, with the following impact:

1. Less money has an emotional impact; and

2. Less money means that these elderly people do not have the means to pay for treatment for mental health problems.

The above information on poverty and mental health illness is not conclusive, but is a general observation.

PREPARED TESTIMONY OF THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

Mr. Chairman, I am Sammy Griffin, a Licensed Practical Nurse, Executive Director of the North Carolina Licensed Practical Nurses Association, and National President of the National Federation of Licensed Practical Nurses.

As you know, Mr. Chairman, our national organization recently held its annual convention in Miami during the first of this month. We were disappointed to learn that your plane was unavoidably detained in Iceland, but we greatly appreciated your thoughtfulness in asking your very able staff director, Bob Weiner, to represent you. His keynote address to the nearly 2,000 present at that evening's ceremonies was both inspiring and informative. We were impressed by his knowledge of his subject matter and his dedication to you and your important work. We look forward to working with you both.

The National Federation of Licensed Practical Nurses is the professional organization of LPN's and is exclusively comprised of Licensed Practical Nurses. Presently, there are approximately 600,000 Licensed Practical Nurses throughout the country who are an integral part of the health care team. As the nation's second largest group of health providers, LPN's play a vital role in the delivery of health care services, and because we provide these services in a wide range of settings, we are keenly aware of our nation's health needs.

One such area where we find present health care services inadequate is for our senior citizens. Besides the staggering statistics of spiraling costs and increasing numbers of people who reach their sixties and can neither afford nor find adequate health care services is the human suffering and the loss of personal pride and dignity because of these inadequacies. As the bedside nurse, we see the needless suffering by many patients.

Of major concern to us is that we perceive a great inability on the part of America to provide adequate health care delivery. The prime reason for this is the underutilization of health care providers and an outdated philosophy that medical care is synonymous with health care.

The National Federation of Licensed Practical Nurses sees the necessity to distinguish between "Medical Care" and "Health Care." It is our contention that Health Care encompasses a broad range of services designed to maintain the physical, mental and social well-being of people. There is no one profession or discipline which can do all this, and if we are to provide the proper planning, delivery and evaluation of health care, if we are to provide a truly comprehensive health care program which will include preventive, diagnostic, therapeutic and restorative or maintenance care, we must use all qualified health providers and produce a system which is both effective and economical.

The burden of providing such care should not fall on one group of providers but rather many different disciplines who are skilled and educationally prepared to offer a wide range of services.

As the nation's second largest group of health providers, we are painfully aware of federal and state policies and programs which encourage participation of only a few professions in the delivery of health care services. We see an urgent need to reverse the policies and programs and fully utilize not only LPN's but other qualified health providers.

These policies greatly affect the cost and quality of present health care programs and waste valuable resources. Specifically, I would like to address myself to three areas of deficiencies in the current medicare program which, because of these requirements, greatly impair the delivery of health care services:

1. Present medicare regulations prohibit and discourage alternatives to institutional care because of their skilled nursing requirement.

2. Present Medicare requirements which limit the number of home health care visits to 100.

3. Present medicare requirements which mandate prior-hospitalization before an individual becomes eligible for home health care services.

We see these requirements as needless and costly barriers which prevent low cost quality health care delivery.

The inadequate utilization of home health care benefits is due primarily to the medicare requirement for "skilled nursing care." The government has selected a series of medically-oriented tasks and observations and defined them as "skilled" care and limited reimbursement eligibility to these tasks, thereby eliminating many preventive and maintenance services needed to keep the elderly out of hospitals and other institutions. An elderly widow in North Carolina, who was weak and palsied, needed certain eye medication administered on a daily basis, but because of her infirmities, she could not administer the medication herself. Though the actual giving of the medication would take less than one minute, as a result of such impractical regulations, medicare did not pay for the services because it wasn't termed "skilled" nursing care.

Clearly, one could see that this artificial and unnecessary requirement for reimbursement severely impairs the ability of LPN's and others to provide needed services.

Similarly, 600,000 LPN's who are educationally prepared to do many of the tasks as the Registered Nurse cannot provide that service because of the use of the word "skilled." We want to emphasize a point here, Mr. Chairman, that the thrust of our argument in no way lessens the quality of care, but merely utilizes more effectively and efficiently those practitioners who have been educationally prepared.

What is particularly encouraging about the full utilization of health care practitioners is that it will eventually enable more people to enter the delivery system. We feel that this action in the long run will encourage greater use of home health benefits and reduce dependency on more costly institutional care.

Congress has just recently recognized that some medicare and medicaid policies are too restrictive and prevent the utilization of many health care providers. The Rural Health Clinic bill establishes a more multi-level and multi-disciplined approach where health services would be provided by practitioners other than physicians. We think that this is a step in the right direction and should be expanded to include LPN's and other qualified health providers.

The second area of professional concern to us regarding the limitations in the present medicare program is that present requirements limit the number of home health visits to 100. This restriction, too, prevents the needed delivery of health care on a need basis and becomes costly when the maximum home health visits are used and institutionalization is required.

Many elderly people are prone to chronic long-term illnesses and the 100 visit limitations under parts A and B of medicare expire before the patient has had sufficient opportunity to recovery. Unlimited home health care would also discourage the use of hospitals and institutions and would provide a more familiar and welcome convalescent place to an elderly individual.

Also, through the expanded role of such health providers as LPN's in a situation where home health visits would be unlimited, preventive and diagnostic services could be delivered and perhaps save a patient from becoming ill, save money as well, and spare the patient possible hospitalization. We do know that it costs less to prevent an illness than it does to treat it.

It is in these areas that new and expanding roles for RN's, LPN's and other providers can help keep people out of hospitals and yet provide them with quality care. We must add at this point, however, that the unlimited use of home health visits should be closely tied to an effective utilization review program and that this review mechanism should be developed and administered by representatives of all providers rendering service.

Our third area of concern is that present medicare requirements which mandate prior-hospitalization before an individual becomes eligible for home health care services are too costly. Last Spring, we learned that each day American taxpayers pay $48 million for hospital care under medicare-medicaid.

The Department of Health, Education, and Welfare estimated that in fiscal year 1976, the medicare program spent more than 75 percent of its funds for hospitals and nursing home care. They report that in 1976, $55 billion was spent on hospital care alone and that if present trends continue, total spending on hospital care in 1986—just 9 years from now—will be a staggering $220 billion.

Many times, in an effort to assist a patient in receiving needed benefits, physicians will unnecessarily admit a patient to a hospital so that the patient will be eligible for home health or nursing home care. We see that not only is this costly, but it causes a physician to choose between properly treating his patient or complying with the law.

In addressing these three areas, we hope that we have been helpful to the Committee in pointing out glaring gaps in medicare which impact on the quality of health care delivery as well as the cost. Needless to say, we all have a stake in the system which now treats our elderly. In our desire to provide necessary health services, we must constantly evaluate the present system, correct its glaring deficiencies and inefficiencies and remember that our goal is to maximize health care delivery services and minimize costs. We suggest that the three medicare regulations discussed here today impede the process and keep us from our goal.

This Committee has traditionally been one of the leaders in articulating the health needs of our citizens, especially the elderly. We applaud your efforts, we are proud to work with you, and we eagerly await the day when all those in need of health care are able to receive the best care at a reasonable cost.

Appendix 3

Prepared Statement of the American Optometric Association on Medicare Gaps and Limitations

The American Optometric Association, which represents over 20,000 doctors of optometry and optometry students commends this committee for its continuing efforts to serve the elderly citizens in our country.

Proper vision care is one of the overlooked needs of the elderly, as vision problems are among the most prevalent of all health problems in our country. The percentage of our citizens requiring vision care to maintain good vision performance increases to approximately 96 percent at age 70.

Optometrists are specifically trained and state licensed to examine the eyes and related structures to detect the presence or absence of vision problems, eye disease and other abnormalities. They provide treatment by prescribing ophthalmic lenses, contact lenses or other optical aids, and by providing vision therapy when indicated to preserve or restore maximum efficiency of vision.

By gathering information and thoroughly evaluating the eyes, internally and externally, and related structures, optometrists can detect systemic diseases such as diabetes, hypertension, and arteriosclerosis, brain tumors and other neurological conditions, and eye diseases such as glaucoma and cataract that require referral to other health care practitioners for treatment.

Optometry is the third largest independent health care profession and provides two-thirds of our nation's vision care in geographical settings ranging from the inner-city to suburban, small town and rural areas of the country. Due to its accessibility and its scope of service, optometrists should be reimbursed under Medicare for services they are specifically trained and licensed to provide. Yet under the existing Medicare program, Medicare beneficiaries are unable to go to their optometrist for vision care because, with the exception of filling aphakic prescriptions, the optometrist is not reimbursed for his examination under Medicare.

Optometrists practicing at their highest level of skill, constitute an important element of the health care provided to the elderly. The role of optometry in general health care is obvious when one considers the disease signs and symptoms detected by a thorough optometric examination of the eye and its related structures.

The profession of optometry is immediately capable of meeting the vision needs of our elderly population throughout the country and we urge the Committee to recognize the lack of covered optometric services as one of the major gaps in the Medicare system.

The National Cancer Foundation, Inc.,
New York, N.Y., October 18, 1977.

To: Hon. Claude Pepper, Chairman,
Subcommittee on Health and Long-Term Care,
Select Committee on Aging,
United States House of Representatives.

From: The National Cancer Foundation, Inc. and Cancer Care, Inc.

Re: Gaps in the medicare program.

The National Cancer Foundation, Inc. and Cancer Care, Inc. has for over 31 years offered comprehensive social services to 374,000 advanced cancer patients and their families. During 1976–1977 we served 26,212 patients and family members. As in previous years, nearly one-half of the patients we served were over 65 years of age and Medicare eligible. We are, therefore, very familiar with the Medicare program. We know where it works well, and where it needs to be broadened so that the aging may be served more satisfactorily and economically.

We also base our statements on our research study, The Impact, Costs, and Consequences of Catastrophic Illness on Patients and Families.[1] Published in

[1] Copies of this study were sent to the Subcommittee on Health along with our April 15, 1975 testimony on National Health Insurance, and the study was published in the official record of the April hearings.

1973, this study documented the profound financial problems with which the families of advanced cancer patients must deal. It revealed the many inadequacies of current medical insurance and Medicare in a catastrophic illness situation. In addition to doctors' fees, hospital bills, drugs and burial costs, the study also identified many other services which were frequently required by the patients and their families:

Homemaker-Home Health Aide, Housekeeper, Home Attendant, Nurse, Domestic, Social Worker, Special Equipment, Laboratory Tests, Patient Transportation, Special Treatment, Food for Home Help, Blood Transfusions, Patient Laundry, Dental, Eye and Hearing Care, Special Diets, Special Clothing, Psychiatric Treatment, Dwelling Modifications, Nursing Home, and Extended Care Facility.

The services of Cancer Care, Inc. are predicated on the belief that most advanced cancer patients want to remain with their families, and that most families want to maintain the patient in the home. Our focus is not only upon the patient's illness, but also upon the family as a whole. Our goals are to help the family, spouse and children cope more adequately with the patient's illness so that family or personal breakdown may be averted.

An integral part of our service is supplementary financial assistance, when needed, to help defray the cost of services in the home, when it is medically feasible to maintain the patient at home. We want to emphasize at this point that over the years we have consistently found that most advanced cancer patients—including those over 65 years of age—if they can be at home at all, can be cared for by homemaker-home health aides.

Our own experience has shown that in very few instances are the older cancer patients in our caseload in need of, or eligible for, the kind of home health services that are covered by Medicare. More commonly, they need some kind of help in the home which can best be described as a mixture of personal care and household services. The following are a few examples of cases for which we provided supplementary financial assistance for care-at-home services:

1. The K's are in their eighties. She has breast cancer, inoperable because of her age and cardiac condition. He has stomach cancer and is on chemotherapy. A full-time homemaker has been able to care for them, and nursing home placements were averted.

2. Mr. D. is a 75-year-old widower whose leg was amputated because of bone cancer. He has been helped to pay for a part-time homemaker who gives him the personal care, (including bathing) which he needs, and does the cooking and general household chores.

3. Another couple, the F's, are in their early 70's. First she, then he, were afflicted by cancer. We have, thus far, been able to help this couple stay together at home by providing supplementary financial assistance for a 40-hour-per-week homemaker. The homemaker accompanies them to the hospital each week for chemotherapy treatments and to the doctors' offices, besides helping with personal care, meal preparation, and light housekeeping.

Many of the limitations and deficiencies of the Medicare program can be traced to its focus on short-term or acute illnesses. Medicare's stringent requirements governing the delivery of home health services are directly traceable to this emphasis. Under Medicare, home health services are allowable only when skilled nursing care, or physical or speech therapy are required. This stipulation explains why home health care accounts for such an extremely small (1 percent) percentage [2] of Medicare expenditures.

Our experience in helping with in-home services to meet the needs of advanced cancer patients and their families provides dramatic evidence to support the proposition that skilled nursing care need not and should not be a prerequisite for home health care.

Time after time we have helped older persons to remain at home while coping with cancer and the prospect of death. And, as was illustrated in the case descriptions we have offered, in many instances, two people, the patient and his or her spouse, were spared very costly nursing home placements. We note in this connection that it is common in the over-65 age group that each spouse has a severe or chronic illness.

Medicare's part-time home health visits can meet only very specific nursing needs of some patients. Valuable as this may be, it answers only a small part of the problem faced by the elderly ill. The major problem is one of overall care and supportive services to maintain the patient and keep the home intact.

[2] Report of the Committee on Home Health Care of the Department of Health, Education and Welfare's Health Insurance Benefits Advisory Council, September 10, 1974.

Some have suggested that the children of older patients should supply the overall care to maintain their ill parents. However, in our experience this often is not possible because of geographic distances between parents and children, and the fact that daughters and daughters-in-law, who traditionally cared for older persons in the family, often are working themselves.

We must be realistic about the changing patterns that have occurred in our highly industrialized and mobile society, and we must not create legislation that is based on former ways and conditions. Surely we, as a civilized nation and society, owe to those who have spent a lifetime as constructive citizens at least decent and comprehensive medical care in their old age. They must also be given the opportunity to live out their remaining days with as much dignity as possible. This can only be achieved through the provision of a broad variety of home-based services, as well counseling services, so that the elderly may be helped to cope with the problems of illness and old age.

We would like to conclude by offering the following specific recommendations:

1. That present restrictions limiting home health care services to part-time and intermittent skilled nursing care be removed and time limitations imposed upon home health visits be extended.

That the definition of a home health aide be expanded to include such other supportive services as housekeeping. In fact, the title should really be "homemaker-home health aide." Medicare coverage should be extended to include a broad variety of home-based services. The scope and type of service to be utilized should be planned and periodically reviewed by a professional team which might include some or all of the following disciplines: physician, nurse, social worker, or therapist. The social worker should also be available to counsel the patient and family.

2. The "post-hospital" requirements for home health services must be eliminated. Such requirements create severe hardships as well as unnecessary hospitalizations, which frequently are recommended in order to qualify for reimbursement from Medicare for eventual home health services or nursing homes.

3. Medicare should provide coverage, on an out-patient basis, for drugs, medications, and other treatments, such as chemotherapy. This last item is an extremely costly one, and creates severe hardships for the elderly who often must live on low, fixed incomes. Likewise, coverage must be broadened for dental, eye and hearing care.

4. Medicare should also provide coverage for all the recognized skills and professions needed by the elderly. Recent legislative proposals have singled out psychologists for such coverage. While there is coverage for medical social work services (under the direction of a physician) in hospitals, nursing homes, and home health services agencies, there is no coverage for counseling services offered by trained social workers under the auspices of social agencies or licensed mental health clinics. The mental health needs of the elderly must not be overlooked, and social work is one of the helping professions uniquely equipped with skills to meet these needs.

5. Medicare's requirements for co-insurance and deductibles should be removed. We view such requirements as constituting deterrents to early and timely medical attention, and, therefore, early detection of illness. Also, these requirements are administratively costly, and represent a penny-wise, but pound-foolish philosophy.

To sum up: Medicare coverage must be broadened, in the ways we have outlined, so that it will finally meet the needs of the elderly ill in a more realistic and humanitarian manner. The time has come for a truly comprehensive and worthwhile health insurance program for our older citizens.

Thank you for this opportunity to present our agency's views.

AMERICAN PSYCHIATRIC ASSOCIATION,
October 21, 1977.

Hon. CLAUDE PEPPER,
Chairman, House Select Committee on Aging,
U.S. House of Representatives, Washington, D.C.

DEAR CHAIRMAN PEPPER: On behalf of the 23,000 members of the American Psychiatric Association, I would like to congratulate you on your involvement and deep concern about the well-being of older Americans throughout the country. Your national reputation as one of the key Congressional advocates for the elderly is well deserved.

I was saddened to hear of your wife's illness which kept you from attending the hearing on the service gaps in Medicare and the impact such omissions have on the health of the elderly.

In view of the APA's interest and deep concern about providing quality mental health for the elderly, I hope you can make this letter a part of the hearing record since one of the crucial Medicare gaps which we believe must be addressed is mental health coverage.

Unfortunately, the Committee while addressing the question of whether Medicare coverage for mental health treatment was adequate, did not have the opportunity to hear testimony from the medical professional society which could speak specifically to the treatment needs of the mentally ill. As you may know, the APA is uniquely familiar with this area, and members of the Association have been deeply involved in the work of the President's Commission on Mental Health, on behalf of the elderly, and indeed, every service group.

In 1971, the APA Task Force on Aging, established to report on critical mental health issues facing the 1971 White House Conference on Aging, pointed out that progress made during the previous two decades had been infinitesimal. Among the reasons cited were the growth in number of the aging population, the recognition that their diversified needs may require diversified services, and the attitudinal problem of those working with or more appropriately, refusing to work with the elderly.

It is a sad commentary to note that today, many of the same problems exist, and the population of elderly persons continues to increase. In many ways, our recognition that diversified services are needed has languished, unimplemented. While the attitudinal problem has been relieved to some extent, we can all still see the effects of insidious ageism throughout society, including, I must admit honestly, the practice of medicine.

We know that the elderly are disproportionately subject to emotional and mental problems—leading the World Health Organization's list of incidences of new cases of psychopathology of all types per 100,000 population at a staggering 236.1, compared with 93.0 in the next lower age category. Suicides also increase with age, with the elderly who represent ten percent of the population accounting for 25 percent of the suicides nationally. We are aware that older persons are affected more readily by many common everyday emotional problems, complicated by their growing physical and sensory incapacities. Further, we are aware that if NIMH Biometry predictions hold true, about eighty percent of the elderly persons who need assistance for emotional disturbances by 1980 will never be served.

Yet our Federal structure of medical insurance for the elderly has developed few means of dealing with this ever-increasing problem. It continues to cling regrettably and tenaciously to the view that medical care needs of the elderly are short-term, episodic in nature and singular rather than multiple in cause. The stress under Medicare is on inpatient treatment for acute rather than chronic illness. Nowhere is this more clear than in the restriction under Part A which limits lifetime availability to a psychiatric hospital to 190 days, and the restriction under Part B which limits annual outpatient coverage for mental illness to $250 per year—including ancillary medical services.

The out-patient elderly mentally ill restriction violates the mandate of the Older Americans Act to insure older persons independence, integrity and vitality in society at large.

We support the Mental Health Association testimony that the restrictions imposed on psychiatric care must be lifted. No other area of medicine has as much need for psychiatric care as does the elderly.

We do not agree, however, that organized settings are the only ones in which mental illness can be treated. We believe that older persons, indeed all Americans, should have the right to select the setting in which they will receive care. Moreover, we believe that trained physicians, psychiatrists, are indeed crucial to the diagnosis, evaluation and treatment of mental illness particularly in the elderly since the masking effect physical or emotional disturbances have on each other is much more prevalent in the elderly. Physician supervision, whether in private or public settings, is therefore critical.

Psychiatrists are and must continue to be present and involved in the treatment of Medicare patients' mental illness. They have developed national standards of quality which must be met by those in the profession. The peer review mechanism which the APA has developed and which has been implemented na-

tionally can insure cost-effective, quality treatment for mental illness and concomitant physical illness, which cannot be assured otherwise.

We do not believe that Medicare patients suffering from mental illness should be singled out from all other older persons on Medicare for less than equal treatment. We do not believe that Medicare patients suffering from mental illness should be denied freedom to choose a public or private, inpatient or outpatient setting for their mental health care. We do believe that mentally ill Medicare patients should be afforded the highest quality of care for as long as it is needed. This is consonant with the philosophy of the Older Americans Act, and should become the thrust of the Medicare program as well. We hope your Committee will support the end of this discrimination which work against thousands of older persons.

Sincerely,

JACK WEINBERG, M.D.,
President.

PREPARED STATEMENT OF THE AMERICAN SPEECH AND HEARING ASSOCIATION

On behalf of its 27,000 members and the 20 million communicatively-handicapped Americans they serve, the American Speech and Hearing Association wants to express its gratitude to the Select Committee on Aging for providing a public forum to examine the unmet health-related needs of the nation's older citizens. Our particular interest centers on the thousands of elderly Americans whose hearing impairment denies them the opportunity to participate in our communicative society.

The speech-language pathology and audiology professions are the primary disciplines concerned with the systems, structures and functions of individual human communication with special reference to speech, hearing and language; with the causes and effects of delay, maldevelopment and disturbance in human communication; and with the prevention, diagnosis, screening, evaluation, habilitation and rehabilitation of individuals with speech, hearing and language disorders.

The speech-language pathologist or audiologist holding the Certificate of Clinical Competence has satisfactorily evidenced his ability to provide independent clinical services to persons who have disorders of communication in the area certified. To qualify for the Certificate of Clinical Competence, the speech or hearing professional must have at least a master's degree or its equivalent, three hundred clock hours (300) of supervised clinical experience within this training/academic institution, the equivalent of nine months of full-time professional experience (Clinical Fellowship Year) performed after completion of the requisite academic and clinical experience, and he must have achieved a passing score on the National Examinations in Speech-Language Pathology and Audiology administered by the Educational Testing Service, Princeton, New Jersey. As of July 1, 1977, 21,674 members have been awarded the Certificate of Clinical Competence [17,952 in speech-language pathology and 3,722 in audiology with 1,117 members holding dual certification in both speech-language pathology and audiology.]

Recipients of health services rendered by speech-language pathologists and audiologists include children and adults with such identifiable disorders as receptive and/or expressive language impairment, stuttering, chronic voice disorders and serious articulation problems affecting social, emotional, educational and/or vocational achievement; and, speech and language disorders accompanying conditions of hearing loss, cleft palate, cerebral palsy, mental retardation, emotional disturbance, multiple handicapping conditions and other sensory and health impairments.

The most recent federal government data puts at 20 million the number of communicatively-handicapped Americans. Approximately half of all Americans over the age of 65 suffer significant bilateral hearing impairment which is sufficiently severe so as to restrict their understanding of speech. Americans suffering from aphasia (a condition resulting in a significant reduction in language function) caused primarily by cerebral vascular accident (stroke), vascular lesions, cerebral trauma or tumors are estimated to number 600,000. Laryngeal carcinoma, or cancer of the larynx, comprises three to five percent of all human cancer and results in removal of the larynx with total loss of voice among 6,000 Americans annually. Americans plagued by central communication disorders (e.g., impairments of speech and language resulting from cerebral disorders or mental retardation) were estimated at 2.1 million, and those with speech disorders at an astonishing 10,000,000.

Before describing our experience with the current federal health programs and our suggestions for improving delivery under Medicare, we should like to compliment the Chairman, Mr. Pepper, on his advocacy on behalf of the communicatively-impaired elderly. Knowledge of the sensitivity and receptiveness of the members of this forum makes the way smooth for expression of our views on behalf of the communicatively-impaired elderly.

MEDICARE COVERAGE OF SPEECH AND HEARING SERVICES

Speech-language pathology services are available to Medicare Part A recipients when they are inpatients of a Medicare-certified hospital, either by a speech-language pathologist who is employed by the hospital, or by a speech-language pathologist who provides services under contractual arrangements with the hospital. The hospital bills the fiscal intermediary and reimburses the speech-language pathology provider under the terms of the contract. Speech-language pathology services are also available to patients of skilled nursing facilities as an extended care benefit and through home health agencies as a home health benefit.

Under Part B, speech-language pathology services may be provided in a hospital outpatient speech and hearing clinic; the speech-language pathologist may be either an employee of the hospital or provide the services under contractual arrangements with the hospital. Speech-language pathology services are also available in a medical clinic, public health agency or rehabilitation agency. Speech and hearing clinics are rehabilitation agencies under Medicare regulations. Part B also covers speech-language pathology services as a home health benefit.

Medicare speech-language pathology services are presently rendered under the "prudent buyer concept." The fiscal intermediary evaluates a claim for speech-language pathology services by considering the amount a prudent, well-informed buyer would be willing to pay for such a service in that particular area—i.e., the "going rate."

Medicare will not pay for speech-language pathology services rendered in the office of a private practitioner under any circumstances. Medicare provides coverage for speech-language pathology services only if the physician has approved a plan of treatment which he recertifies as necessary every 30 days.

The words "audiology" and "audiologist" do not appear anywhere in the Medicare statute. Audiology services may only be provided under the rubric of "and other diagnostic tests" [Public Law 89-97, sec. 102(a), 79 Stat. 322; 42 U.S.C. § 1395 x(s) (3)]. The full range of audiological services cannot, however, be reimbursed because rehabilitation services are not "diagnostic tests" and section 1862(a) (7) of the Social Security Act which states,

> Sec. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
>
> * * *
>
> "(7) where such expenses are for * * *, hearing aids or examinations therefor, * * *

forbids coverage of audiologic testing. In defining "other diagnostic tests" covered only under Part B Medicare, the services must be performed by a physician or, in the case of otologic examinations, by a qualified audiologist when a physician orders such testing for the purpose of obtaining additional information necessary for his evaluation of the need for, or appropriate type of, medical or surgical treatment for a hearing deficit or a related medical problem. The audiologist is capable of billing directly to the fiscal intermediary and receiving direct payment while using the physician's provider number. The audiologist may additionally be either in independent practice, on the staff of a non-physician-directed clinic or in professional group practice with the physician.

MEDICAID COVERAGE OF SPEECH AND HEARING SERVICES

Thirty-three states provide some degree of speech and hearing services. Twenty-five states provide hearing aids to adults. Since speech and hearing services are optional with the states, the health care cost crunch has made itself felt in a number of state cutbacks of speech and hearing services, making the need for Medicare coverage of these services all the more essential.

PROBLEMS UNDER THE PRESENT SYSTEM

One of the most persuasive forms of overutilization in the health care delivery system has been the programatic overreliance on the physician as overseer of all aspects of health care. In obtaining services through outside resources, the hospital, skilled nursing facility or home health agency becomes the sole claimant for reimbursement, although such entity may be acting as a conduit for one or more outside resource providers (e.g., speech-language pathology, physical therapy, medical supplies, drugs). The speech-language pathologist in rendering services to a patient as an outside resource contractor must submit his bill to

the hospital, skilled nursing facility or home health agency which in turn submits it, together with numerous other accounts, to its fiscal intermediary. The fiscal intermediary, based on the definition of "reasonable cost," will then reimburse the claimant hospital, skilled nursing facility or home health agency, and not the speech-language pathologist. This convoluted payment mechanism has caused a great many speech-language pathology providers to experience untoward delays in receiving payment for services rendered.

Through complaints by its members, ASHA is becoming increasingly alarmed at institutional overcharges to Medicare for speech and hearing services provided on a part-time or intermittent basis. Institutional middlemen are not only skimming the cream off the top but taking most of the milk, too. Under current regulations, institutional providers may bill Medicare for therapists' services provided on a part-time basis at the hourly rate that it would pay for a full-time employee, plus overhead. For part-time services less than 15 hours per week, the institution may bill Medicare the reasonable going rate. The result is that Medicare is paying the same unit charge for therapy services whether or not the institution employs a therapist full-time or part-time. But the therapist working part-time is in many cases getting only a small fraction of the amount Medicare is being billed. In one case reported to our office, a hospital billed Medicare $20 per hour, while paying the speech pathologist only $3 per hour. Thus, Medicare is paying for institutional costs unrelated to the provision of speech pathology services. While this situation could be addressed by yet another technical rulemaking, the proliferation of which is itself adding to the crippling costs of health care, there is a more direct and more effective way: allowing audiologists and speech pathologists to receive direct reimbursement for their services by recognizing those in private practice as qualified Medicare providers, commensurate with their level of training and expertise.

The millions of dollars saved by eliminating the red tape of the contractual arrangements form of payment could go directly toward the provision of services. All it would take is an effective, meaningful peer review system and recognition of the professionalism and independence of qualified health care practitioners by allowing them to be "providers" for reimbursement purposes.

Reimbursement formula for reasonable costs

A problem has occurred following the recent establishment of reasonable cost guidelines for all health care services furnished under arrangements. Public Law 92–603, section 251(c), as amended by Public Law 93–233, section 17(a), created a new reimbursement formula for contract services based on the 75th percentile of the range of salaries paid in the area for the health professionals working in a full-time employment setting. Previously, reimbursement represented reasonable costs not in excess of what a prudent and cost-conscious buyer would pay for the given services. New regulations recently were published applicable only to physical therapy services. The Department of Health, Education and Welfare could not extend the application of the regulation beyond physical therapy services because the establishment of guidelines for salary equivalency are tied to the 75th percentile of statistics developed by the Department of Labor's Bureau of Labor Statistics. Such statistics base information exists only for physical therapy. In its introductory remarks to the final regulations, the Department of Health, Education and Welfare stated:

"Guidelines will be developed, as may be necessary, for the other services at a later date after consultation with the appropriate organizations. Until such guidelines are issued for a specific therapy, the costs of these therapy services will continue to be evaluated so that such costs do not exceed what a prudent and cost-conscious buyer would pay for the given services." [40 F.R. 5760.]

The costs of speech-language pathology services and physical therapy services are two completely unrelated entities as recognized by the language quoted above. This Association has, however, received evidence from members that the physical therapy guidelines are being forced upon speech-language pathologists as a condition of employment or contractual "under arrangements" operations.

Speech-language pathology as an other related therapy

Medicare presently requires that speech-language pathology services be prescribed by a physician [Social Security Act, section 1861(p)(2)]. This came about due to an unfortunate lumping of speech-language pathology services with physical therapy services in the 1972 Amendments. It has been an uphill fight by this Association and its members to convince the Congress and the Department of Health, Education and Welfare that physicians and speech-language pathologists

who relate professionally do so on a non-prescription basis. Physicians who believe a given patient's condition might be improved by speech-language pathology services refer that patient to a speech-language pathologist. The determination as to whether such services in fact contribute to the patient's improved communication skills is exclusively the speech-language pathologist's, as are decisions regarding the "amount, type and duration" of the speech-language pathology services to be rendered. To say that such determinations reside solely with a prescribing physician misrepresents both past and current practice.

The statutory language of Title XIX was not so structured as to force physician prescription of speech-language pathology services. The Social and Rehabilitation Service demonstrated its recognition of the professional relationship by very clearly differentiating between the manner in which health care providers relate with physicians and the manner in which speech-language pathologists and audiologists relate with physicians.

" 'Services for individuals with speech, hearing and language disorders' are those diagnostic, screening, preventive or corrective services provided by or under the supervision of a speech pathologist or audiologist in the practice of his profession for which a patient's referred by a physician. [45 C.F.R. 249.10(b)(11)(iii)]

Speech Pathologist (profess. & kin.) 079.108. Diagnoses, treats, and performs research related to speech and language problems: Diagnoses speech and language disorders by evaluating etiology. Treats language and speech impairments, such as aphasia, stuttering, and articulatory problems of organic and nonorganic etiology. Plans, directs, or conducts remedial programs designed to restore or improve communicative efficiency. Provides counseling and guidance to speech and language handicapped individuals. May act as consultant of education, medical, or other professional groups. [Bureau of Employment Security, United States Department of Labor, Dictionary of Occupational Titles: 1965, Volume I. Washington: Government Printing Office, 1965.]

Contrast the definition of physical therapist:

Physical therapist (medical ser.) 079.378. physiotherapist. Treats patients with disabilities, disorders, and injuries to relieve pain, develop or restore function, and maintain maximum performance, using physical means, such as exercise, massage, heat, water, light, and electricity as prescribed by physician (medical ser.): Applies diagnostic and prognostic muscle, nerve, joint and functional ability tests.

The Department of Health, Education and Welfare in its most recent compilation of health professions, Health Resource Statistics—Health Manpower and Health Facilities, 1974, recognizes the independent nature of speech-language pathology and audiology.

"Speech pathologists and audiologists are primarily concerned with disorders in the production, reception, and perception of speech and language. They help to identify persons who have such disorders and to determine the etiology, history, and severity of specific disorders through interviews and special tests. They facilitate optimal treatment through speech, hearing, and language remedial procedures, counseling, and guidance. They also make referrals for medical or other professional attention."

Their perspective of speech-language pathologists and audiologists, as indicated by the underlined portion of the text, has changed to include their referral to other health professionals and not from.

The only thing which has prevented this general recognition of the independent status of speech-language pathologists and audiologists is the language contained in the statute itself.

The inclusion of outpatient speech-language pathology services under Medicare was instigated by the Committee on Finance, United States Senate, by adding section 283 to H.R. 1 (92nd Congress). The Senate's report language in stating, "Individuals should continue as under present law, to be referred by a physician for services furnished by or under the direct supervision of a qualified speech therapist," emphasized the position of the Senate that speech-language pathology services were then being accompanied by physician referral and not prescription.

In reporting out the bill H.R. 3153 (93rd Congress, 1st Session), the Senate's Committee on Finance once again tried to clarify the misconception created in Public Law 92–603, section 283, by the tacking of speech-language pathology services onto the definition of physical therapy services. Unfortunately for Americans with communicative impairments, the Conference Committee of the two

Houses failed to reach agreement on any substantial provisions of H.R. 3153 and passed a skeleton compromise bill (H.R. 11333) providing an increase in Social Security benefits. The Senate report stated:

"Under present law speech pathology services are covered under Medicare when provided by approved hospitals, skilled nursing facilities, or home health agencies. Additionally, P.L. 92–603 provided that speech pathology services are covered on an outpatient basis when rendered in an organized setting.

"The provision in P.L. 92–603 unintentionally penalized the speech pathologist. By incorporating through reference certain requirements applicable to physical therapy, the provision seemed to require that for Medicare reimbursement for speech pathology services there must be not only a physician's referral but also a specific physician's plan detailing the amount, duration and scope of services to be provided by the speech pathologist.

"Since speech pathology involves highly specialized knowledge and training, physicians generally do not go into this type of detail when referring a patient for these services.

"The Committee bill therefore clarifies that a physician's referral need not necessarily detail the amount, duration and scope of services required. The Committee notes that there would still be a requirement for physician referral and the physician would still be required to periodically review the relationship between the services rendered and his total plan of health care for the patient. Additionally, there would continue to be a requirement that the speech pathologist have a detailed plan of treatment which could be reviewed." [S. Rept. 93–553, pages 66–68.]

The dilemma faced by the Department of Health, Education and Welfare in trying to promulgate rules, regulations and guidelines recognizing the professional status of speech-language pathologists and audiologists consonant with the language of the Social Security Act has now, for almost ten years, been an insuperable barrier to health care for communicatively-impaired Americans. This Association firmly hopes that continuation of this untenable position will not be carried over in any change from the present health care system to a national health insurance plan. We are hopeful that, during this session, Congress will enact the technical amendment necessary to carry out the true intent of the Senate Finance Committee.

Physician as sole entry point to health care system

The most significant deterrent to Medicare's, and most of Medicaid's, provision of quality and cost-efficient speech-language pathology and audiology services involves the position occupied by these two professions in the total health care delivery system as seen by the Congress and the "qualified providers" (i.e., hospitals, skilled nursing facilities and home health agencies).

At present, the only entry point into the Medicare-Medicaid health system is through the physician. Titles XVIII and XIX recognize the physician as the only qualified person to determine whether each and every health care service is warranted. He must establish and periodically reevaluate a plan of treatment; certify and rectify the patient's need for the services; certify that he has established and periodically reviewed the plan of treatment; and assure that he is the physician for the patient. Diagnostic and rehabilitative procedures proliferate along with sophisticated technology and new health care specialties. The position occupied by the physician is not, today, in real proportion to his actual role. This Association has always sought a meaningful, cooperative relationship with physicians in providing comprehensive, quality health care services to the communicatively impaired, be those services preventive, diagnostic, habilitative or rehabilitative in nature. The physicians with whom speech-language pathologists and audiologists actively work—general and family practice physicians, pediatricians, neurologists, otologists and otolaryngologists—have full respect for our professional competence and special knowledge.

The system created to insure fiscal responsibility has itself become one of the prime generators of unnecessary and wasteful administrative costs in the Medicare and Medicaid programs. To insure fiscal responsibility, the system has frustrated the intent of Congress, placed great financial burdens on health professions forced to operate "under arrangements"—for those even willing to take the gamble—and, most importantly, deprived Americans with communicative disorders who qualify for services from being given the chance to return to a useful and meaningful place in our society.

Audiologic rehabilitation

One of the most glaring incongruities in the Medicare program is that it has ignored the most important health problem among the elderly—loss of hearing. According to the Federal Council on Aging, over half of persons aged 65 and over suffer from impaired hearing. Yet the federal health program specifically designed to address the health problems of the nation's geriatric population totally disregards their need for hearing health care. We fully endorse Mr. Pepper's untiring efforts on behalf of the nation's elderly and legislation such as H.R. 1127 which he introduced.

Coverage of the full range of audiologists' services, even excluding paying for the hearing aid itself, would provide a direct subsidy to recipients, enabling them to purchase hearing aids only when they are suited to the individual's loss and choosing the best and cheapest aid for their purposes, based on the audiologist's recommendation.

It is interesting to note that a recent Veterans Administration survey of some 700 veterans receiving hearing aids through its system recommended solely by audiologists revealed 57 percent retained the same device for eight years or longer, while 28 percent kept their aids for 12 years or longer. Contrast this with the present public, unregulated over-the-counter system here the "Annual Facts and Figures" of the hearing aid industry document the average hearing aid wearer's acquisition of a new device every 3.28 years.

Audiologists' services, however, are far broader than merely hearing aid related services, and their services can be easily separated from the hearing aid itself.

Unlike eye problems correctable by eyeglasses, a hearing problem is not solved by hanging a hearing aid on the ear. First, the hearing aid may not be helpful at all, depending on the person's type of hearing loss. The audiologist is the nonmedical health professional best trained to determine the type of hearing loss and the need for an aid. Second, it takes a new wearer time to adjust to hearing through an aid, to build up a tolerance to electronic sound and to learn to discriminate speech through the electronic medium. The audiologist has received a minimum of three year's training in counseling techniques such as speech reading and situational training to maximize aided or unaided hearing. Therefore, when this Subcommittee makes recommendations about rehabilitative services which should be included in Medicare, we respectfully request that it recommend coverage of audiologic rehabilitation.

In summary, the members of our profession are unquestionably the experts in communicative disorders which affect 20 million Americans. They have distinguished themselves as participating health care practitioners under Medicare, Medicaid, Title V (Crippled Children's programs), vocationaal rehabilitation, Veterans Administration and Department of Defense health programs. They practice in a wide variety of settings, such as hospital speech and hearing clinics or departments, freestanding outpatient speech-language pathology and audiology clinics, university outpatient clinics, outpatient rehabilitation facilities (e.g., National Easter Seal Society and United Cerebral Palsy centers), Veterans Administration hospitals, private practice and in public and private schools. They have a particular concern with communication problems so prevalent in the nation's aging population.

National Health Insurance is just around the corner. Members of this Subcommittee recognize that we must put our house in order and correct past mistakes before they are concretized into a broader federal commitment. It is essential at this time to clarify ambiguities and eliminate prevailing laxity. Toward this end, the American Speech and Hearing Association respectfully requests consideration of these proposals:

1. Clarification of section 1861(p) to eliminate the need for physician prescription and patient-plan monitoring for speech pathology services.
2. Extension of Medicare benefits to cover audiologic rehabilitation.
3. Recognition of speech pathologists and audiologists in private practice as qualified Medicare providers whose services are directly reimbursable.

BIPARTISAN COMMITTEE FOR MEDICARE OVERSEAS,
Paris, France.

STATEMENT ON THE NEED FOR MEDICARE BENEFITS FOR AMERICANS OVERSEAS

The Medicare law provides that anyone eligible for its benefits may receive them within the United States or its territories but not elsewhere (with minor exceptions). The effect of this exclusion (Title XVIII, Section 1814) is in practice to deny health care benefits to otherwise entitled Americans living abroad, or travelling abroad, who may be too ill to return for treatment of a serious case, or in a less severe case where the cost of travel might not justify the trip.

Since eligible Americans living abroad have paid into the Social Security Fund, and pay income taxes, which are the primary sources of Medicare financing, they lack not only the prepaid health protection they need but have helped finance programs from which they cannot benefit—a very unfair situation. What is more, there is no reason to believe that actuarial cost estimates for medicare have taken account of persons who become eligible for benefits but are geographically prevented from receiving them to reduce the need for revenue, so that contributions may actually include an element to pay for such benefits even though they are not available.

All of the leading American organizations abroad strongly support the Bipartisan Committee in its efforts to change the Medicare law to provide health services outside as well as inside the United States. They include the Association of American Residents Overseas, the American Legion, the American Chambers of Commerce, the Federation of American Womens Clubs Overseas and many others.

As those living abroad who have recently incurred health care costs in the United States will know, U.S. costs are higher than in almost any other country. Accordingly the services provided under Medicare abroad will be less costly than if those eligible were taken care of at home as they are entitled to be.

In the United States, the Medicare program is vast with more than 25 million people eligible for benefits. But abroad, authorities estimate that of the total U.S. civilian population of from two to three million—larger than that of the five least populous states—fewer than 225,000 would be eligible. Close to one-third of these live in neighboring Canada and Mexico and already have relatively easy access to U.S. medical facilities. In Europe, perhaps 2,000 would be found eligible in France, 7,000 in the United Kingdom, 9,000 in West Germany and 25,000 in Italy.

The Department of State has for many years successfully provided care for its employees and for veterans in private medical facilities abroad, while maintaining adequate cost and quality controls. However, State would apparently welcome an extension of the availability of Medicare benefits abroad. to take care of elderly dependents of its employees who may not receive benefits under its present program.

Blue Cross is another example of an organization which has effectively provided health insurance abroad.

Some years ago, an earlier Paris-based Committee attempted to have Medicare benefits extended overseas but it found HEW fearful that costs and difficulties of administration would prove too great and that health facilities and services might not measure up to acceptable American standards. But times and conditions are changing and Mr. Wilbur J. Cohen, who was Under Secretary and later Secretary of HEW when the original Medicare law was passed and implemented, now believes health care should be provided overseas, as do others now more familiar with the question.

With this encouragement, the Bipartisan Committee prepared a bill which, in all but one respect, covers the same ground as H.R. 5264. The Committee believes this bill will meet the problems which had given rise to earlier HEW opposition. Under the bill the long-range plan would be to conclude bilateral

reciprocal agreements with other countries, which would provide a flexible means of meeting the widely varying conditions abroad. Such agreements already exist among many countries including a multilateral agreement among the nine members of the European Common Market which permits workers and tourists from any member country to obtain social security medical benefits in any other member country.

In countries with well developed health services, HEW could have confidence that they could perform the important function of certifying that hospitals and medical personnel paid by Medicare are properly qualified. American hospitals abroad which have been accredited by the American Hospital Association would also be qualified. They include the American Hospital in Paris, the Hospital Infantil in Mexico, the Hospital des Servidores da Estrado in Brazil, and the Dharien Health Center in Saudi Arabia.

On a reciprocal basis, health agencies abroad might also assume other administrative burdens, with HEW undertaking similar services for a country that wished to provide health services to its citizens in the United States.

Since the negotiation of international agreements customarily proceeds with less than notable speed, and in some cases conditions may not be appropriate for them, the bill proposes that pending the conclusion of such agreements HEW would be authorized to extend Medicare hospital benefits abroad unilaterally, as an interim measure. In such cases, practical experience within a country would help in negotiating a better bilateral agreement.

The Bipartisan Committee believes that the bill should be broadened to provide overseas the outpatient services available under Part B of the Medicare law. Blue Cross is already administrating private insurance claims abroad but coverage is not generally available to those over 65. In any case, those wishing these Medicare services must pay a special premium which covers part of the expense. Indeed if the premium is not paid from the outset, even by people abroad, HEW requires them to pay a higher premium when they later decide to subscribe. Even if administrative costs prove to be somewhat higher than in the United States, medical costs would generally be considerably less than in the U.S. The Committee sees no basis for denying these services to Americans overseas and discriminating against them as compared with those at home. Failure to make available Part B services would stimulate undesirable pressures to hospitalize patients who do not require inpatient services.

Turning to the bill itself, special reference might be made to those sub-sections of the proposed new Section 1880 which are in the nature of safeguarding assurances that the program will operate within the parameters of the Medicare program at home. Thus, only persons eligible in the U.S. would be eligible abroad; benefits abroad would be no greater than at home; reciprocal arrangements for health services in the U.S. would be provided only to the classes of beneficiaries eligible for Medicare, and, as in the U.S., beneficiaries would equitably share the costs with the health programs financed by governments.

The last section of the bill should also be especially noted. This provision makes it clear that Medicare will *not* bear health costs abroad which are presently borne by programs of a foreign country.

The Bipartisan Committee urges the early passage of this bill with the change suggested. It is administratively practical; it will cost no more than if these services were provided at home; and in simple justice Americans abroad are entitled, since they contribute through their taxes to the program, to receive the health care so vital to older citizens.

[From the International Herald Tribune, Aug. 17, 1976]

AMERICANS ABROAD AND MEDICARE

(By Alfred E. Davidson)

Paris—Longtime U.S. residents abroad—especially those approaching 65 or older—are generally aware that Medicare benefits are not available to them overseas. But millions of other Americans who live in the United States, and are eligible for Medicare, probably do not know that if they are taken ill while traveling outside the country, Medicare will not help them bear any medical expenses they incur.

The Medicare law is drafted in a curious way. As individuals living abroad, one may be eligible for Medicare. But to obtain Medicare benefits, everyone with minor exceptions, must go to the United States. Of course, this is generally impractical for people abroad who are really sick or, for money reasons, for those with lesser ailments. As a result, all Americans abroad who are eligible in the United States for Medicare may face a serious health care problem.

As those who have incurred health costs recently in the United States will know, U.S. costs are higher than in almost every country so that the extension of Medicare abroad will be less costly than if those eligible were taken care of at home as they are entitled to be.

In the United States, the Medicare program is vast, with about 30 million people eligible for benefits. But abroad, authorities estimate that of the total U.S. population of from 2 to 3 million civilians—larger than that of the five least populous states—fewer than 150,000 would be eligible. Close to half of these live in neighboring Canada and Mexico. Perhaps 2,000 would be found eligible in France, 7,000 in Britain, 9,000 in West Germany and 25,000 in Italy.

The Veterans' Administration has provided, in a quiet way, a convincing demonstration that health benefits can be made available abroad at reasonable cost and without great administrative difficulty. It provides health services to eligible veterans through local facilities in countries where there are no U.S. military facilities—as in France. About 100 veterans received medical benefits in France last year and only the part-time help of one U.S. Embassy officer and a few local personnel were required to administer the program. Blue Cross is another example of an organization that has effectively provided health insurance abroad.

Some years ago, an earlier Paris-based committee attempted to have Medicare benefits extended overseas, but it found the U.S. Department of Health, Education, and Welfare fearful that costs and difficulties of administration would prove too great and that health facilities and services might not measure up to acceptable U.S. standards.

But times and conditions are changing. Wilbur Cohen, who was secretary of HEW when the original Medicare law was passed, is now on our side. He met two years ago with interested U.S. citizens and the American Hospital of Paris directors and concluded that Medicare benefits should be made available overseas.

On a reciprocal basis, health agencies abroad might also assume a large part of the administrative burden, with HEW undertaking similar services for a country that wished to provide health services to its citizens in the United States.

But the negotiation of international agreements customarily proceeds with less than notable speed and in some countries conditions may not be appropriate for bilateral agreements. A new bipartisan committee, based in Paris, is proposing that, pending the conclusion of bilateral agreements, HEW should be authorized to extend Medicare benefits abroad unilaterally on a basis similar to the Veterans Administration program. There has already been much too long a delay in caring for Medicare needs overseas.

Congress passed laws over many years slowly giving the vote to different minority groups who had been disenfranchised—women, blacks, individuals under 21, and last of all, this year, American living abroad. In the case of Medicare, Americans abroad are still the neglected minority. But now that they have the vote, the bipartisan committee is hopeful—especially in this presidential year—that the political powers will listen more attentively and that early action will be taken.

SUPPORTERS OF MEDICARE FOR AMERICANS ABROAD

American Club of Dusseldorf, Dusseldorf, Germany, American Club of the Costa del Sol, Malaga, Spain, American Club of Hamburg, Hamburg, Germany, American Club of Lisbon, Lisbon, Portugal, American Club of Zurich, Zurich, Germany, American Chamber of Commerce in France, Paris, France, American Chamber of Commerce in Italy, Milan, Italy, American Chamber of Commerce of Mexico, Mexico City, Mexico, American Chamber of Commerce in Morocco, Morocco.

American Chamber of Commerce in Thailand, Bangkok, Thailand, American Aid Society of Paris, Paris, France, American Cathedral Men's Club, Paris, France, American Center for Students and Artists, Paris, France, American College in Paris, Paris, France, American Hospital of Paris, Neuilly-sur-Seine, France, American Legion, Department of France, Paris, France, American School

of Paris, Paris, France, American Society of Barcelona, Barcelona, Spain, American Society of the River Plate, Buenos Aires, Argentina.

American Legion Auxiliary, Paris, France, American Women's Group in Paris, Paris, France, Association of American Chambers of Commerce in Latin America, Washington, D.C., Association of Americans Resident Overseas, Paris, France, Association of American Wives of Europeans, Paris, France, Atlantic Institute for International Affairs, Paris, France, British-American Club of Majorca, Palma de Mallorca, Baleares, Spain.

Chamber of Commerce of the United States in the Argentine Republic, Buenos Aires, Colombia, American Chamber of Commerce, Bogota, Columbia, Council on International Educational Exchange, Paris, France, Fondation des Etats-Unis, Paris, France, Institute for International Research, London, England, Junior Guild of the American Pro-Cathedral, Paris, France, Maltese American Association, Valletta, Malta, Veterans of Foreign Wars of the United States, Benjamin Franklin Post 605, Paris.

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